Dental Benefit Plan Manager

Systems Companion Guide

July 2014
Version 1.0

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Section 1

Change Control Table

The Department of Health and Hospitals will provide maintenance of all documentation changes to this Guide using the Change Control Table.

Author of Change	Sections Changed	Descriptions	Reason	DATE
Gustave Lehmann	**Appendix J**	**Dental Data Elements**	**Added Dental Data Elements**	**6/26/2014**
Gustave Lehmann	**Appendix F**	**MMIS Error Code with Short and Long Description**	**Added the list of edits**	**6/26/2014**
Darlene White	**Section 3**	**Claim Received Date, Claim Paid date, Interest Paid Amount**	**Corrected language**	**6/27/2014**
Gustave Lehmann	**Section 2**	**Supplementation of CMS-1500**	**Removed**	**6/30/2014**
Gustave Lehmann	**Appendix G**	**Provider Registry Edit Report (sample)**	**Updated**	**7/2/2014**
Gustave Lehmann	**Appendix G**	**Provider Registry Edit File Layout**	**Updated**	**7/2/2014**
Gustave Lehmann	**Appendix G**	**Provider Registry Site File**	**Removed**	**7/2/2014**
Gustave Lehmann	**Appendix G**	**Site File Format**	**Removed**	**7/2/2014**
Gustave Lehmann	**Appendix G**	**Error Messages**	**Removed**	**7/2/2014**
Gustave Lehmann	**Appendix K**	**Electronic File Layout for TPL**	**Added example of the layout**	**7/2/2014**
Gustave Lehmann	**Appendix K**	**Molina TPL File Layout to plans**	**Added example of the layout**	**7/2/2014**

Section 2

Overview

DHH will require the Dental Benefit Plan Manager, herein referred to in this Guide as the Plan, to report complete and accurate encounter data for all Medicaid eligible enrollees. Encounters include all paid services provided to Medicaid enrollees. The Plan will be required to submit complete and accurate encounters to the Fiscal Intermediary (FI) using HIPAA v5010 compliant Provider-to-Payer-to-Payer COB 837D (Dental) transactions.

Definition of an Encounter

Encounters are records of medically related services rendered by a Plan provider to Medicaid recipients enrolled in the Plan on the date of service. It includes all services for which the Plan has any financial liability to a provider. An encounter is comprised of the procedures(s) and/or service(s) rendered during the contract. The Plan must report all paid and denied services covered under the Contract. Encounter services include core benefits and services to Medicaid members based on their eligibility groups as specified by DHH in Section 5 of the RFP for the eligibility groups.

Purpose of Encounter Collection

The purposes of encounter data collection are as follows:

Contract Requirements

For encounter data submissions, the Plan shall submit ninety-five (95%) of its encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the Plan has a capitation arrangement with a provider.

Rate Setting

The Balanced Budget Act of 1997 (BBA) requires the use of base utilization and cost data that is derived from the Medicaid population in order to produce actuarially sound capitation rates. Rates are actuarially sound if they are appropriate for the covered Medicaid population and the services are provided under the Contract. In addition, CMS requires basing rates upon at least one year of recent data that is not more than five years old.

In full consideration of the Contract services rendered by the Plan, DHH agrees to pay the Plan monthly payments based on the number of enrolled Members and other relevant cohort distinctions (age, gender, geographic location, Medicaid category of assistance, etc.).

Quality Management and Improvement

The DBP is a Medicaid Program partially funded by CMS. The Plan is required to collect and report performance measures (PM) data that demonstrates adherence to clinical practice and/or improvement in patient outcomes. Measures as defined by DHH, include Health Care

Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality (AHRQ) measures and/or other measures as determined by DHH as outlined in the contract. DHH will use encounter data to evaluate the performance of the Plan and to audit the validity and accuracy of the reported measures.

Continuous Quality Improvement Plan for Oversight and Assessment of Medicaid Coordinated Care

According to the BBA, a written quality strategy plan is required to serve as the guiding principles for assessing the quality, effectiveness, and efficiency of services rendered to Medicaid enrollees. The goal of the quality strategy plan is to purchase the best value health care and services for DHH beneficiaries, to improve access to services for underserved and vulnerable beneficiary populations, and to protect them from substandard care. The objectives of the plan are to assess, monitor, and measure the improvement in health care and behavioral health services provided directly or through referrals to Medicaid beneficiaries, and to ensure the accuracy in claim payments for services rendered.

Continuous quality improvement focuses on measuring and improving the quality of the encounter data available to DHH. Data from the Plan will continue to undergo data quality checks beyond the minimum criteria used in the edit process. The results of both the encounter edit codes and ongoing data quality monitoring are combined to develop plan-specific Quality Strategic Opportunity Plans (encounter quality improvement plans).

Implementation Date

Within sixty (60) days of operation, the Plan's Systems shall be ready to submit encounter data to DHH's FI in a HIPAA compliant provider-to-payer-to-payer COB format. All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (D – Dental). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.

DHH Responsibilities

DHH is responsible for administering the Dental Benefit Program. Administration includes data analysis, production of feedback and comparative reports, data confidentiality, and the contents of this Systems Companion Guide. Written questions or inquiries about the Guide must be directed to:

Mary Johnson
Department of Health and Hospitals
Bureau of Health Services Financing
Bayou Health Program
628 North 4th St.
Baton Rouge, LA 70821
Phone: (225) 342-1304
Fax: (225) 342-9508 **Email:** **mary.johnson@la.gov**

DHH is responsible for the oversight of the Contract and Plan activities. DHH's claim responsibilities include production and dissemination of the Systems Companion Guide, the initiation and ongoing discussion of data quality improvement with the Plan, and Plan training. DHH will update the Systems Companion Guide on a periodic basis.

Fiscal Intermediary (FI) Responsibilities

Molina is under contract with DHH to provide Louisiana Medicaid Management Information System (LMMIS) services including the acceptance of electronic claim and encounter reporting from the Plan. DHH's FI will be responsible for accepting, editing and storing 837D encounter data. The FI will also provide technical assistance to the Plan during the Electronic Data Interchange (EDI) testing process.

The Plan will receive daily incremental recipient Member File updates, a weekly full Member File, and a weekly full provider extract. During the Design, Development and Implementation phase (DDI), the Plan will receive an initial file of claims and encounters representing two (2) years of historical data, and then on a weekly basis, the Plan will receive a weekly incremental file of claims and encounters data. The Plan will also receive a capitation payment each month for each Medicaid eligible as defined in the RFP, and a monthly ANSI ASC X12N v5010 820 file representing the detail payments by member.

X12 Reporting

If the file contains syntactical errors, the segments and elements where the error occurred are reported in a 999 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship.

After claim adjudication, an ANSI ASC X12N v5010 835 Remittance Advice (835) will be delivered to the Plan, if requested. The Plan must prearrange for receipt of 835 transactions.

Proprietary Reports

The FI will also provide the Plan with proprietary MMIS encounter adjudication edit reports following the weekly encounter processing cycle. In addition, a monthly financial reconciliation report (820) will coincide with payment of the PMPM. The file layout can be found in Appendix D of this Guide.

Dental Benefit Program (Plan) Responsibilities

The Plan shall be able to transmit, receive and process data in HIPAA compliant or DHH specific formats and/or methods including but not limited to secure File Transfer Protocol (FTP) over a secure connection such as Virtual Private Network (VPN, that are in use at the start of the Systems readiness review activities). Plan generated reports are described in Appendix E of this Guide.

It is also the Plan's responsibility to ensure accurate and complete encounter reporting from their providers.

The Plan must evaluate the adequacy of, and revise if necessary, the data collection instruments and processes being used by its providers. With regard to provider identification, the Plan is responsible for ensuring that the appropriate NPI, taxonomy and 9-digit zip code are submitted in each transaction.

The Plan is expected to investigate the findings of encounter denials and be prepared to explain the underlying reasons for the identified data quality issue(s). As data issues are discussed, the Plan must incorporate corrective action steps into the encounter quality improvement plan. Any issues that are not fully addressed on a timely basis may be escalated into a corrective action plan (CAP). The CAP will include a listing of issues, responsible parties, and projected resolution dates.

Section 3

Transaction Set Supplemental Instructions

Introduction

The HIPAA transaction and code set regulation requires that covered entities exchanging specified transactions electronically must do so using the appropriate ANSI ASC X12 EDI formats (presently v5010). Further, HIPAA has defined how each of these transactions is to be implemented. Implementation instructions are contained in detailed instruction manuals known as implementation guides (IGs). The IGs provide specific instructions on how each loop, segment, and data element in the specified transaction set is used.

The 837 formats used for DHH are the 837D Dental Provider-to-Payer-to-Payer Coordination of Benefits (COB) Model, as defined in the HIPAA IGs.

This Guide will not provide detailed instructions on how to map encounters from the Plans systems to the 837 transactions. The 837 IGs contain most of the information needed by the Plan to complete this mapping.

The Plan shall create their 837 transactions for DHH using the HIPAA IG for Version 5010. On January 16, 2009, HHS published final rules to adopt updated HIPAA standards; these rules are available at the Federal Register. Should HHS update the HIPAA IG to a new version, the Plan will be responsible for migrating applications to that new version, according to the timelines issued by HHS.
In one rule, HHS is adopting X12 Version 5010 for HIPAA transactions. For Version 5010, the compliance date for all covered entities is January 1, 2012.

The ANSI ASC X12N 837 (Healthcare Claim Transactions – Institutional, Professional, and Dental) Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12N National Implementation Guide. The ANSI ASC X12N Implementation Guides can be accessed at http://www.wpc-edi.com/content.

Molina Companion Guides and Billing Instructions

Molina, as DHH's FI, provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 format(s). If the file contains syntactical error(s), the segments and elements where the error(s) occurred are reported in a 999 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. The FI HIPAA Companion Guides can be found at www.lamedicaid.com or www.lmmis.com. Select HIPAA Billing Instructions and Companion Guides from the left hand menu.

DHH Supplemental Instructions

DHH requires the Plan to submit the Provider-to-Payer-to-Payer COB Model of the 837. There can be multiple COB loops. The loops in the 837 HIPAA implementations that are used to convey information regarding adjudication are the 2320 (Other Subscriber Information), 2430 (Service Line Adjudication Information) and 2330B (Other Payer information). In the first COB

loop, the Plan will be required to include information about the Plan provider claim adjudication, including the claim amount paid and payment date as recognized by the Plan. In the first loop, the Plan shall place their unique DHH carrier code in loop 2300B, NM109. Molina will assign the unique carrier code to the Plan. In subsequent loops, the Plan shall provide DHH with any third-party payments. In these loops, the Plan must include the DHH carrier code of the other payer. There can be only one single subsequent loop per unique payer.

Health Plan Carrier Code Assignment

Plan Name: Dental Benefit Plan Assigned Carrier Code: 999997

Batch Submissions

The Plan may submit batch encounters, up to 99 files per day. Each batch encounter file is restricted to 20,000 CLM records.

Plan Internal Control Number (ICN)

The Plan ICN is to be populated in Patient Control Number, Loop 2300, CLM01. The number that the Plan transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the Plan to use the value in this field as a key in the Plan's system to match the encounter to the information returned in the 835 transaction.

DHH requires the Plan to modify the ICN to contain a 4-digit prefix as follows:

Character 1: Standard claim submission media types are:

- **"P"** to indicate submission of claim via paper form
- **"E"** to indicate submission of claim via electronic submission
- **"W"** to indicate the submission of claim via web portal

The Plan must provide a Data Dictionary if other media types are submitted.

Character 2: Claim paid/denied status

The Plan or their Delegated Vendor must indicate the status of the claim for this character position as follows:

- **"P"** for paid encounters
- **"D"** for denied encounters

Character 3-4: Vendor information.

The Plan should provide a data dictionary that indicates which vendor or organization the claim was paid by. As vendors are changed, an update to the data dictionary is required.

Financial Fields

DHH requires the Plan to report the following financial fields:

Header and Line Item Submitted Charge Amount — The Plan shall report the provider's charge or billed amount. The value may be "$0.00" if the Plan contract with the provider is capitated and the Plan permits zero as a charged amount. If the submitted charge is billed as "$0.00", the MMIS will calculate the paid amount as zero since DHH pays the lesser of the submitted charge or the calculated fee amount. A value other than "$0.00" must be submitted when the provider bills on a fee-for-service (FFS) basis. The maximum charge or billed amount that can be submitted is 999999.99.

Header and Line Item PLAN Paid Amount — If the Plan paid the provider for the service, the Paid Amount shall reflect the amount paid. If the service was not covered by the Plan or was covered under a sub-capitation arrangement, "$0.00" is the appropriate Paid Amount. This amount is stored in the encounter as a Third Party Liability (TPL) amount.

Header and Line Item Adjustment Amount — If the Paid Amount reflects any adjustments to the Submitted Line Item Charge Amount, the adjustment amounts must be reported. Any time the charge amount does not equal the paid amount, the Plan is required to report both the Adjustment Amount and the adjustment reason code. The adjustment amounts and reason codes are critical to the correct pricing of the encounter in the MMIS.

Claim Received Date

The Plan is required to submit the Plan's Claim Received Date in 837-D encounter data.
The Claim Received Date will be sent in Loop 2300 in the REF*D9 Segment using date format yyyymmdd.

Claim Paid Date

The Plan is required to submit the Plan's Claim Paid Date in 837-D encounter data.

For Inpatient records, the Claim Paid Date will be sent in Loop 2330B in the DTP*573 Segment.

For non-Inpatient records, the Claim Paid Date will be sent in Loop 2430 in the DTP*573 Segment.

Interest Paid Amount

When the Plan pays Claim Interest, the Plan is required to submit the Plan's Claim Interest Amount and Paid Date in 837-D encounter data. The Claim Interest data will be sent in a distinct set of COB Loops, separate from the set of COB Loops that the Plans use to send their claim adjudication data.

In the Claim Interest set of COB Loops, instead of using the Plan's unique DHH Carrier Code (99999x), a value in INT99x format will be used; where the last digit is the same last digit from the Plan's unique DHH Carrier Code value.

For non-Inpatient records, in the Claim Interest set of COB Loops, the total claim Interest Paid Amount will be sent in AMT02 of the Loop 2320 AMT*D Segment. The service-line Interest Paid Amount will be sent in SVD02 of Loop 2430. The service-line Interest Paid Amount will also be sent in CAS03 of Loop 2430 using CAS02 value 225. The Interest Paid Date will be sent in the DTP*573 Segment of the Loop 2430 service-lines.

Professional Identifiers

The Plan is required to submit the provider's NPI, Taxonomy Code and 9-digit zip code in each encounter. If the last four (4) digits of the zip code are unknown, then the Plan may substitute "9999".

BHT06

The BHT06 is used to indicate the type of billed service being sent: fee-for-service (claim) or encounter. Use a value of RP when the entire ST-SE envelope contains encounters. RP is used when the transaction is being sent to an entity (usually not a payer or a normal provider payer transmission intermediary) for purposes other than adjudication of a claim. If the RP value is not used, either the entire batch of encounters will be rejected, or the batch will be processed as claims, which will result in the denial of every claim.

Transaction Type

Appendix J of this Guide contains tables to provide guidance on the use of 837s. This guidance is subject to change.

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Section 4

Repairable Denial Edit Codes and Descriptions

Introduction

DHH modified edits for dental encounter processing. A list of these edits can be found in Appendix F of this Guide.

Encounter Correction Process

DHH's FI will send edit code reports (CP-0-90) to the Plan the day after they are produced by the MMIS adjudication cycle via the web. The Plan is required to submit corrections in accordance with an approved quality assurance plan.

Resubmissions

The Plan may make corrections to the service line(s) to which a repairable edit code was applied.

If an encounter is denied in its entirety, the Plan may resubmit the encounter once it has been corrected.

Section 5

Transaction Testing and EDI Certification

Introduction

The intake of encounter data from the Plan is treated as HIPAA 5010 837 format compliant transactions by DHH and its FI. As such, the Plan is required to undergo Trading Partner testing with the FI prior to electronic submission of encounter data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, the Health Plan is requested to send real transmission data. The FI does not define the number of encounters in the transmission; however, DHH will require a minimum set of encounters for each transaction type based on testing needs.

If a Plan rendering contracted provider has a valid NPI and taxonomy code, the Health Plan will submit those values in the 837. If the provider is an atypical provider, the Plan must follow 837 atypical provider guidelines and consult with the FI regarding the appropriate provider identifier.

Prior to testing, the Health Plan must supply DHH with documentation of provider information publicly available through the Freedom of Information Act (FOIA) from the National Provider and Plan Enumeration System (NPPES). The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. In addition, DHH will provide the Plan with a list of provider types and specialties (see Appendix J). The Plan is to provide the provider type and specialty in addition to the data elements available through NPPES.

Test Process

The Electronic Data Interchange (EDI) protocols are available at:
http://www.lamedicaid.com/provweb1/billing_information/medicaid_billing_index.htm or
www.lmmis.com/provweb1/default.htm and choosing Electronic Claims Submission (EMC).
Below are the required steps of the testing process.

Electronic Data Interchange (EDI)

Enrollment as an EDI submitter is achieved through the completion of the DHH/FI approval process and the successful testing of provider encounters of a particular claim type. The FI EDI Coordinator is available to assist in answering questions, but enrollment and participation proceed through the following steps:

- Upon request from the Health Plan, the FI will provide application and approval forms for completion by the submitter. When completed, these forms must be submitted to the FI Provider Enrollment Unit.
- During the authorization process, the Health Plan can call the EDI Department to receive EDI specifications that contain the data and format requirements for creating EDI claims. Using these specifications, the potential submitter develops and tests application software to create EDI encounters.
- Molina requires the Health Plan to certify with a third-party vendor, EDIFECS, prior to submitting test claims to Molina.
- When the submitter is ready to submit a file of test encounters, the test encounters shall be submitted to the FI EDI Coordinator using the submitter number: 4509999. The test

submission is run through Louisiana Medicaid Management Information System (MMIS) programs that validate the data and formats. Reports produced from this testing are reviewed by the FI. The test results are verified and the submitter is contacted to review any problems with the submission. If necessary, additional test encounters will be submitted until an acceptable test run is completed. **This test submitter number (4509999) shall be used for submission of test encounters only!**

When all forms have been received and approved by the FI's Provider Enrollment Unit, and the EDI Department has verified the test claims, the submitter will be notified that EDI encounters may be submitted.

Once the Plan becomes an approved EDI submitter, the billing process will be as follows:

- Upon receipt of the submission, the FI's EDI Department logs the submission and verifies it for completeness. If the submission is not complete, the log is rejected and the submitter is notified about the reject reason(s) via electronic message or telephone call.
- If the certification form is complete, the EDI Department enters the submitted encounters into a pre-processor production run. The pre-processor generates an encounter data file and one report. The Claims Transmittal Summary report, which lists whether a provider's batch of encounters has been accepted or rejected, is generated for each submission. If a provider's encounters are rejected, the provider number, dollar amount and number of encounters are listed on the report.

The Plan will submit to DHH and its FI a test plan with systematic plans for testing the ASC X12N 837 COB. The plan consists of three (3) tiers of testing, which are outlined in Appendix H.

Timing

The Plan may initiate EDIFECS testing at any time. DHH's FI Business Support Analysts are ready to answer technical questions and to arrange testing schedules and EDIFECS enrollment. Please refer to the FI Companion Guides for specific instructions, located at: www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm

Editing and Validation Flow Diagram

A flow chart depicting an incoming ANSI ASC X12N 837 transaction validation for syntax of the FI Electronic Data Interchange (EDI) is located in Appendix N.

Data Certification

The BBA requires that when State payments to the Plan are based on data that is submitted by the Plan, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State. Encounter files submitted by the Plan, which are used to create payments and/or capitated rates, must be certified by a completed signed Data Certification form, which is required to be faxed concurrently with each encounter submission. The data must be certified by one of the following individuals:

1. DBP's Chief Executive Officer (CEO); or
2. DBPs Chief Financial Officer (CFO); or
3. An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

Certification shall be submitted concurrently with the certified data. (**Appendix O**)

Section 6

Data Management and Error Correction Process

Introduction

Encounter data is submitted through the FI's Electronic Data Interchange (EDI). Once received, 837 transactions are subject to initial edits. Further edits are applied during MMIS encounter processing.

Rejection Criteria

Incoming 837s may be rejected either at the FI's Electronic Data Interchange (EDI) or during the MMIS encounter processing. At the FI's Electronic Data Interchange (EDI), there are four levels (batch, syntax, claim header or service line) where edits (data validation processes) are present. Rejection of an entire batch or a single encounter is designated by the edit level in which the error occurs. Line level errors may also occur in the MMIS processing system. DHH will require the Health Plan to correct certain MMIS line level errors.

Entire File

Rejection of an entire batch is designated by the edit level in which the error occurs. Interchange Level Errors will result in the rejection of an entire batch and the generation of a TA1 Rejection Report.

The TA1 is an ANSI ASC X12N Interchange Acknowledgement segment that is used to report receipt of individual envelopes. An interchange envelope contains the sender, receiver, and data type information for the header. If the syntactical analysis of the interchange header and trailer is invalid, the interchange will reject and a TA1 will be forwarded to the Molina Call Center. In this scenario, the entire transaction is rejected at the header level.

Once the transaction has passed interchange edits, it shall be subject to transaction set syntax errors. If the error occurs at the ST or SE level segments, the entire transaction is rejected. These edits are reported on the ANSI ASC X12N v5010 999.

Claim

Transactions with errors at the ST or SE level segments are rejected in their entirety. However, if the functional group consists of additional transactions without errors, these transactions are processed. The 999 transaction contains ACCEPT or REJECT information. If the file contains syntactical errors, the segment(s) or elements(s) where the error(s) occurred are reported.

Once the transaction has passed through syntactical edits, the transaction is edited according to implementation guide rule sets and payer-specific requirements. Any errors that occur at this level will result in the data content within that encounter being rejected. The ANSI ASC X12N

824 may be used to report those errors.

Service Line

Data that passes the FI's edits will proceed to the data transformation step for processing. In this step, certain data elements are converted into a format that is acceptable for claims processing. During processing, the MMIS will apply specific edits to the encounters. Depending upon the level of edit, an individual encounter may deny at the header or at a single detailed line.

A full listing of encounter edits will be contained in Appendix F in a later version of this Guide. After processing, an 835 Remittance Advice is returned to the sender.[1]

Error Correction Process

The Plan is required to correct and resubmit any transactions or encounters that are rejected in their entirety. For service line rejections, the Plan is required to correct and resubmit errors that are known to be "repairable". A list of repairable denials will be contained in a later version of this Guide.

Entire File

The Plan will receive either a TA1 or X12N 999 error report. The Plan is required to work with the FI's Business Support Analysts to determine the cause of the error.

Claim/Encounter

The Plan will receive either an X12 835 or proprietary reports for header level rejections. The Health Plan is responsible for adherence to the implementation guide, code sets, and looping structures for the transaction. The Health Plan will also be responsible for adhering to the DHH payer-specific data rules, as defined in the FI's Companion Guide and Section 2 of this Guide.

Service Line

The Plan will receive an X12N 835 for transaction claims that have processed through the MMIS. If the service line fails MMIS encounter edits, an adjustment reason code, adjustment amount, and adjustment quantity are returned in the CAS segment of loop 2110.

This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the encounter. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory in the 835 IG, for additional information.

A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used

[1] If requested by the Plan and prearranged with DHH

to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

Each adjustment reason is associated with a particular MMIS edit code. The Health Plan is presented with an edit code report to assist them in identifying repairable errors. The Health Plan is responsible for correcting and resubmitting service line denials.

Outstanding Issues

After implementing the data management and error correction process and any processing error(s) remaining unresolved, the Plan may present the outstanding issue(s) to DHH and/or its FI for clarification or resolution. DHH and/or its FI will review the issue(s) and triage the issue(s) to the appropriate entity for resolution, and respond to the Health Plan with their findings. If the outcome is not agreeable to the Plan, then the Plan may re-submit the outstanding issue(s) with supporting documentation to DHH for reconsideration. The outcome as determined by DHH will prevail.

Dispute Resolution

The Plan has the right to file a dispute regarding rejected encounters. Disputes must be filed within thirty (30) days of identifying an issue for dispute. The Plan may believe that a rejected encounter is the result of a "FI error." A FI error is defined as a rejected encounter that (1) the FI acknowledges to be the result of its own error, and (2) requires a change to the system programming, an update to MMIS reference tables, or further research by the FI, and therefore requires FI resolution to process the rejection.

The Plan must notify DHH in writing within thirty (30) calendar days if it believes that the resolution of a rejected encounter rests on the FI rather than the Plan. The FI, on behalf of DHH, will respond in writing within thirty (30) days of receipt of such notification. DHH encourages the Plan to provide written notice as soon as possible. The FI response will identify the status of each rejected encounter problem or issue in question.

For ease in filing written requests, the Plan may use the Edit Reports provided by the FI. The Plan shall highlight, or otherwise note, the rejected encounters to be researched, and attach a memorandum describing the problem.

The FI will review the Plan’s notification and may ask the Plan to research the issue and provide additional substantiating documentation, or the FI may disagree with the Plan claim of an FI error. If a rejected encounter being researched by the FI is later determined not to be caused by the FI, the Plan will be required to make corrections to the encounter, if appropriate, and resubmit during the next billing cycle.

Section 7

Continuous Quality Improvement

Introduction

In accordance with the Balanced Budget Act (BBA), DHH developed a quality strategy plan that serves as the guiding principles for the establishment of quality improvement efforts for the Plan. Continuous quality improvement is the method to identify opportunities for improving and demonstrating successful interventions for data management. Data from the Plan will continue to undergo data quality checks beyond the minimum criteria used in the MMIS edit process. The result of edits and data quality improvement monitoring are combined to develop plan-specific encounter quality improvement plans. Interim monitoring and follow-up on identified quality problem areas is an integral component of DHH's encounter process.

The encounter quality improvement plan is designed to provide DHH and the Plan with a comprehensive list of data quality issues present in the data for a given period at the time of the report. DHH will meet with the Plan every three (3) months, or as needed. The encounter quality improvement plans are sent by the Plan to DHH in advance of the meeting. The Plan meeting attendees are to include claims and EDI experts, and clinical quality assurance staff.

At the site visit, the Plan is expected to have investigated the findings of encounter quality improvement plans and be prepared to explain the underlying reasons for the identified data quality issue(s). As data issues are discussed, the PLAN must incorporate corrective action steps into a quality improvement report. If issues are not resolved in a timely manner, DHH may request a corrective action plan (CAP). The CAP shall include a listing of issues, responsible parties, and projected resolution dates.

Minimum Standards

There are two components to encounter data quality assessment: Repairable Denials and Data Volume Assessment.

Repairable Denials

Repairable denials must be recorded on the encounter quality improvement plan with a corrective action plan for correcting and resubmitting encounters with line level denials or full encounter denials.

Data Volume Assessment

Data Volume Assessment refers to the evaluation of whether key services meet expected rates of provision, as demonstrated in the data. This is important to decide whether Plans are submitting data and, ultimately, whether the actual level of services are adequate to meet contractual requirements, justify capitation rates, and provide appropriate access to care for the

enrolled population. A core audit function includes determining whether DHH has all of the encounter data generated for a specific period.

Section 8

Adjustment Process

Introduction

In the case of adjustments, the Plan is to follow the detailed, payer-specific instructions provided in the FI's Companion Guides found at:

www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm.

To adjust an encounter with a line level denial, make the correction(s) to the encounter and resubmit using the instructions below.

Line Adjustment Process

Loop	Segment	Data Element	Comments
2300	CLM05-3	1325	**Claim Frequency Type Code** To adjust a previously submitted claim, submit a value of "**7**". See also 2300/REF02.
2300	REF01	128	**Reference Identification Qualifier** To adjust a previously submitted claim, submit "**F8**" to identify the Original Reference Number.
2300	REF02	127	**Original Reference Number** To adjust a previously submitted claim, please submit the **13-digit ICN** assigned by the FI's adjudication system and printed on the remittance advice, for the previously submitted claim that is being adjusted by this claim.

For claim level denials, make the correction(s) and resubmit.

Molina ICN Format

The format of the Molina ICN is as follows:

- Digit 1 = Last digit of year of receipt
- Digits 2-4 = Julian day of the year of receipt
- Digit 5 = Media Code with value of 1(EDI)
- Digits 6-8 = 3 digit batch number
- Digits 9-11 = 3 digit sequential number in batch
- Digit 12-13 = claim line number

Section 9

Date of Death Recovery Process

Each quarter in a calendar year the Fiscal Intermediary will run a Date of Death Recovery Process. The basic concept of the process is to identify recipients who are retrospectively deceased including PMPM payments and generates voids to recover payments.

The process takes the Fiscal Intermediary 2 weeks – the first week to identify the recipients who are retrospectively enrolled, and the second week to process the voids. The Plan will receive Report CP-0-12D with impacted providers.

The report contains the following data elements:
- Recipient ID
- Name
- Claim ICN
- Procedure Code
- Dates of Service
- PMPM Payment

The Fiscal Intermediary will generate an 820 file with the detail information regarding the voids for any past PMPM payments made to the Plan. The process runs quarterly on the following schedule:

Last week of January and first week of February
Last week of April and first week of May
Last week of July and first week of August
Last week of October and first week of November

Upon receiving the report and/or the 820 file, the Plan is to note that recipients are identified as retrospectively deceased and solicit the FI to send them disenrollment information, and then engage recoveries for claims they have paid.

Appendix A

Definition of Terms

The following terms shall be construed and interpreted as follows unless the context clearly requires otherwise.

837 Format	The file format used for electronic billing of professional services, institutional services or dental services. ANSI 837 is shorthand for the ASC X12N 837 file format.
999 Functional Acknowledgment	Transaction set-specific verification is accomplished using a 999 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents.
Administrative Region	Louisiana Medicaid is divided into 9 geographically-defined regions according to the following coded values: 1=New Orleans 2=Baton Rouge 3=Houma/Thibodaux 4=Lafayette 5=Lake Charles 6=Alexandria 7=Shreveport 8=Monroe 9=Covington/Bogalusa
Agent	Any person or entity with delegated authority to obligate or act on behalf of another party.
Atypical providers	Individuals or businesses that bill Medicaid for services rendered, and do not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (e.g., carpenters, transportation providers, etc).
CAS Segment	Used to report claims or line level adjustments.
Capitation Payment	A payment, fixed in advance, the BHSF makes to the DBPM for each member covered under the Contract for the provision of core health benefits and services and

	assigned to the DBPM. This payment is made regardless of whether the member receives core dental benefits and services during the period covered by the payment.
Claim	Means 1) a bill for services 2) a line item of service or 3) all services for one recipient within a bill.
Claim adjustment	A reason why a claim or service line was paid differently than it was billed. Adjustments are communicated by adjustment reason codes.
Claim denial	When a claim does not meet the criteria of being complete or does not meet all of the criteria for payment under Health Plan rules.
Claims adjudication	In health insurance claims, adjudication refers to the determination of the insurer's payment or financial responsibility, after the member's insurance benefits are applied to a medical claim.
Clean claim	A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
CMS 1500	A universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-04.
Coordination of Benefits (COB)	Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
Co-payment	Any cost sharing payment for which the Health Plan member is responsible, in accordance with 42 CFR 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.
Corrupt data	Data corruption refers to errors in electronic data that occur during transmission, retrieval, or processing, introducing unintended changes to the original data. Computer storage and transmission systems use a

	number of measures to provide data integrity and the lack of errors. In general, when there is a Data Corruption, the file containing that data would be inaccessible, and the system or the related application will give an error. There are various causes of corruption.
Covered Services	Those health care services/benefits to which an individual eligible for Medicaid is entitled under the Louisiana Medicaid State Plan and waivers as outlined in the contract's service manual.
Data Certification	The Balanced Budget Act (BBA) requires that when State payments to a Health Plan are based on data that is submitted by the Health Plan, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State.
Denied claim	A claim for which no payment is made to the network provider by the Health Plan for any of several reasons, including but not limited to, the claim is for non-covered services, the provider or Member is ineligible, the claim is a duplicate of another transaction, or the claim has failed to pass a significant requirement (or edit) in the claims processing system.
Department (DHH)	The Louisiana Department of Health and Hospitals, referred to as DHH.
Dental Benefit Program Manager (DBPM)	A risk-bearing, Prepaid Ambulatory Health Plan (PAHP) healthcare delivery system responsible for providing specified Medicaid dental Benefits and services included in the Louisiana Medicaid State Plan to eligible Louisiana Medicaid enrollees.
Duplicate claim	A claim that is either a total or a partial duplicate of services previously paid.
Edit Code Report	A proprietary report prepared by the Fiscal Intermediary that includes all of the edit codes for each claim line and each claim header. Some edit codes indicate that the encounter has denied. Other edit codes are informational

	only.
EDI Certification	EDI Certification essentially provides a snapshot that asserts an entity is capable at that point in time of generating or receiving compliant files. It is based solely on the files that have been tested and submitted for certification. Specifically, it is based on the exact capabilities that are reflected within those files. Testing and certification are typically done through a third party vendor prior to encounters being submitted to the Fiscal Intermediary.
Eligible	An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act.
Encounter data	Healthcare encounter data include: (i) All data captured during the course of a single healthcare encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter; (ii) The identification of the member receiving and the provider(s) delivering the healthcare services during the single encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single encounter.
Fee for Service (FFS)	A method of provider reimbursement based on payments for specific services rendered to an enrollee.
File Transfer Protocol (FTP)	Software protocol for transferring data files from one computer to another with added encryption.
Fiscal Intermediary (FI) for Medicaid	DHH's designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.

Fiscal Year (FY)	Refers to budget year – A Federal Fiscal Year is October 1 through September 30 (FFY); A State Fiscal Year is July 1 through June 30 (SFY).
Fraud	As it relates to the Medicaid Program Integrity, means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.
Health Care Professional	A physician or other healthcare practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other healthcare practitioner includes any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.
Health Care Provider	A health care professional or entity that provides health care services or goods.
HIPAA – Health Insurance Portability Administration Act	The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system will become increasingly effective and efficient.

ICD-9-CM codes (International Classification of Diseases, 9th Revision, Clinical Modification)	Codes currently used to identify diagnoses. The Health Plan shall move to ICD-10-CM as it becomes effective.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Interchange Envelope	Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Internal Control Number (ICN)	DHH's FI assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail. Processing or returning the claim constitutes the FI's final action on that claim. A resubmission of the same claim is considered a new claim. Each claim sent to the FI is assigned an ICN automatically, which is used to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when the FI actually received the claim.
Louisiana Department of Health and Hospitals (DHH)	The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.
Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.
Medicaid FFS Provider	An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, has been approved by DHH, and accepts payment in full for providing benefits, the amounts paid

	pursuant to approved Medicaid reimbursement provisions, regulations and schedules.
Medicaid Management Information System (LMMIS)	A mechanized claims processing and information retrieval system, which all states Medicaid programs are required to have, and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
NEMT	Non-Emergency Medical Transportation
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the Health Plan.
Policies	The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and/or federal rules and regulations.
Prior Authorization	The process of determining medical necessity for specific services before they are rendered.
Protected Health Information (PHI)	Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164.
Provider	Either (1) for the FFS program, any individual

	or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the Health Plan, any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the state in which it delivers services.
Provider Specialty	A second-level qualification code, specific to Louisiana Medicaid, that designates the specialty classification of a provider according to Louisiana State Plan for Medicaid (for example, for physicians, some specialties are General Practice, Pediatrics, Family Medicine, etc.).
Provider Type	A high-level identification code, specific to Louisiana Medicaid, that designates the service classification of a provider according to Louisiana State Plan for Medicaid (for example, physician, dentist, pharmacy, hospital, etc.).
Quality	As it pertains to external quality, review means the degree to which the Health Plan increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.
Quality Assessment and Performance Improvement Program (QAPI Program)	Program that objectively and systematically defines, monitors, evaluates the quality and appropriateness of care and services, and promotes improved patient outcomes through performance improvement projects, medical record audits, performance measures, surveys, and related activities.
Quality Management (QM)	The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.
Readiness Review	Refers to DHH's assessment of the Health Plan's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of Health Plan standards; and review of systems. The review may be done as a desk review, on-site review, or

	combination and may include interviews with pertinent personnel so that DHH can make an informed assessment of the Health Plan's ability and readiness to render services.
Reject	Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 999 (Functional Acknowledgement**)** will be returned to the submitter. The 999 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
Remittance Advice	An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the Health Plan, payments for maternity, and adjustments.
Repairable Edit Code	An encounter that denies for a reason that is repairable (shall be fixed and resubmitted) will have an accompanying "repairable edit code "code" to indicate that the encounter is repairable.
SE Segment	The 837 transaction set trailer.
Security Rule (45 CFR Parts 160 & 164)	Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.
Service Area	The entire State of Louisiana is the service area.
Service Line	A single claim line as opposed to the entire claim or the claim header.
Span of Control	Information systems and telecommunications capabilities that the Health Plan itself operates, or for which it is otherwise legally responsible according to the terms and conditions of the Contract with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the Health Plan.
ST Transaction Set Header	Indicates the start of a transaction set and to

	assign a control number.
Start-Up Date	The date Health Plan providers begin providing medical care to their Medicaid members. Also referred to as operations start date and “go-live date.”
Stratification	The process of partitioning data into distinct or non-overlapping groups.
Syntactical Error	Syntax is the term associated with the "enveloping" of EDI messages into interchanges. Items included in Syntax Set maintenance include: "Delimiters" which separate individual elements and segments within the interchange; "Envelope segments" which denote the beginning and ending of messages, functional groups, and interchanges; and "Permitted Characters" which define the values allowed for a particular syntax set. Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 999 (Functional Acknowledgement**)** will be returned to the submitter. The 999 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
System Function Response Time	Based on the specific sub function being performed: • *Record Search Time*-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor. • *Record Retrieval Time*-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor. • *Print Initiation Time*- the elapsed time from the command to print a screen or report until it appears in the appropriate queue. • *On-line Claims Adjudication Response Time*- the elapsed time from the receipt of the transaction by the Health Plan from the provider and/or switch vendor until the Health Plan hands-off a response to the provider and/or switch vendor.

System Unavailability	Measured within the Health Plan's information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the “enter” or other function key.
TA1	The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 999. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Taxonomy codes	These are national specialty codes used by providers to indicate their specialty at the claim level.
Trading Partners	Covered entities who are involved in Electronic Data Interchange involving HIPAA ANSI transactions.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Appendix B

Frequently Asked Questions (FAQs)

What is HIPAA and how does it pertain to the Health Plan?

The Administrative Simplification provisions of HIPAA, Title II, include requirements that national standards be established for electronic health care transactions. These standards are being adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of EDI in health care. DHH has chosen to adopt these standards for Health Plan encounter data reporting.

What is Molina and what is their role with the Health Plan?

Molina is under contract as DHH's Fiscal Intermediary and responsible for providing functions and services to receive and send ANSI ASC X12N transactions on behalf of their clients.

Is there more than one 837 format? Which shall I use?

There are three HIPAA-compliant 837 transactions — Institutional, Professional, and Dental services. The transactions the Health Plan will use will depend upon the type of service being reported. Further instructions can be found in Section 2 of this Guide.

Whom do I contact if I have a question regarding the EDI Information Sheet or need technical assistance concerning electronic claim submission?

You may contact the Molina EDI Support Unit Monday through Friday, from 8:00 a.m. to 5:00 p.m. CDT, at 225-216-6303.

I am preparing for testing with EDIFECS. Whom do I contact for more information?

For answers to questions regarding specifications and testing, please contact Molina's EDI Business Support Analysts at 225-216-6303.

Will DHH provide us with a paper or electronic remittance advice?
DHH's FI will provide the Health Plan with an electronic 835 Health Care Claim Payment/Advice (ERA), if requested and arranged in advance.

Where can I find HIPAA code lists, including the Claim Adjustment Reason Codes and Remittance Remark Codes, which appear in the 835 Health Care Claim?

The Claim Adjustment Reason Codes provide the "explanation" for the positive or negative financial adjustments specific to particular claims or services that are referenced in the 835.

The Remittance Remark Codes are used in the 835 to relay informational messages that cannot

be expressed with a Claim Adjustment Reason Code. These codes are all nationally mandated codes that must be used by payers in conjunction with the 835.

Payers may no longer use the proprietary codes that they used prior to HIPAA, even if the proprietary codes give better details about how a claim was adjudicated.

HIPAA code lists can be found on the Washington Publishing Company's website at: http://www.wpc-edi.com/codes/.

We understand that DHH will require the NPI, taxonomy code and 9-digit zip of the provider to process the 837 COB. Is this correct?

Yes, that is correct. Effective with claims and encounter submissions after May 23, 2008, all providers are required to have an NPI and taxonomy. DHH will also require that a 9-digit zip code be placed on the encounter.

Does Molina have any payer-specific instructions for 837 COB transactions?

Yes, the Molina Companion Guides contain a number of payer-specific instructions for 837 transactions. The FI Companion Guides can be found at www.lamedicaid.com. Once on the DHH website, choose HIPAA Billing Instructions & Companion Guides from the left hand menu. There are separate companion guides for each of the 837 transactions.

What is a Trading Partner ID?

The Trading Partner ID is a number assigned by the FI for each submitter of encounter data. You are assigned this ID prior to testing.

Why must the Health Plan submit encounter data?

The reasons why the Health Plan is required to submit encounter data are as follows:

1. Encounter Data: Section 17.5.4 of the HEALTH PLAN RFP details the requirements for encounter submission.

2. Rate Setting: The BBA requires the use of base utilization and cost data that is derived from the Medicaid population in order to produce actuarially sound capitation rates. Rates are considered actuarially sound if they are appropriate for the covered Medicaid population and the services that are provided under the Contract.

3. Utilization Review and Clinical Quality Improvement: DHH's Health Plan Program is partially funded by CMS. Encounter data is analyzed and used by CMS and DHH to evaluate program effectiveness and monitor quality of care, utilization levels and patterns, access to care, and to evaluate Health Plan performance. The utilization data from encounter data provides DHH with performance data and indicators. DHH will use this information to evaluate the performance of the Health Plan and to audit the validity and accuracy of the reported measures.

Appendix C

Code Sets

The use of standard code sets will improve the effectiveness and efficiency of Medicaid, Federal, and other private health programs through system administration simplification and efficient electronic transmission of certain health information. *Code set* means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and the descriptors of the codes.

When conducting 837 transactions, DHH requires the Plan to adhere to HIPAA standards governing Medical data code sets. Specifically, the Plan must use the applicable medical data code sets described in §162.1002, as specified in the IGs that are valid at the time the health care is furnished. The Plan is also required to use the non-medical data code sets, as described in the IGs that are valid at the time the transaction is initiated.

DHH requires the Plan to adopt the following standards for Medical code sets and/or their successor code sets:

A. International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9- CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following conditions:

- Diseases;
- Injuries;
- Impairments;
- Other health problems and their manifestations; and
- Causes of injury, disease, impairment, or other health problems

B. ICD-9-CM, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following procedures or other actions taken for diseases, injuries, and impairments on inpatients reported by hospitals:

- Prevention;
- Diagnosis;
- Treatment; and
- Management

DHH is presently engaged with its FI to remediate the Medicaid systems to use the ICD-10-CM and ICD-10-PCS codes sets to comply with DHHS/CMS guidelines for implementation on 10/1/2014.

C. National Drug Codes (NDC), as maintained and distributed by DHHS, in collaboration with drug manufacturers, for the following:

- Drugs; and
- Biologics.

D. Current Dental Terminology (CDT) Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association (ADA) for dental services.

E. The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. Category I CPT codes describe a procedure or service identified with a five-digit CPT code and descriptor nomenclature. The inclusion of a descriptor and its associated specific five-digit identifying G-code number in this category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Services described by Category I CPT codes include, but are not limited to, the following:

- The services manual outlined in the Health Plan contract,
- Physician services,
- Physical and occupational therapy services,
- Radiological procedures,
- Clinical laboratory tests,
- Other medical diagnostic procedures

In addition to the Category I codes described above, DHH requires that the Health Plan submit CPT Category II codes. CPT Category II codes are supplemental tracking G-codes that can be used for performance measurement. The use of the tracking G-codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. Some codes in this category may relate to compliance by the health care professional with state or federal law.

F. The HCPCS, as maintained and distributed by DHHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following:

- Medical supplies,
- Orthotic and prosthetic devices,
- Durable medical equipment. and
- Other services, as applicable, outlined in the Health Plan contract.

Appendix D

System Generated Reports

The overarching purpose of this set of reports is to enhance the quality of the encounter data by providing DHH and the Plan with a basic accuracy and completeness assessment of each claim after each encounter cycle in order that preliminary corrections and repairs can be conducted and the encounter resubmitted to the FI. These reports will take advantage of the existing MMIS reporting capacity for claims data. However, the reports are altered, as necessary, to enhance their usefulness in depicting encounter data errors.

Encounter data is submitted through the FI's Electronic Data Interchange (EDI) and undergoes a series of 837 COB edits, passing through to the MMIS, and then going through a set of edits that will result in summary and repairable edit codes reports and a summary report of the encounter data submitted.

The following reports are generated by the MMIS system and have been selected specifically to provide the Health Plan with useful information that, when compared with the 835 Remittance Advice for the specific encounter, will provide a complete explanation for the edit code. A second set of reports that focus more closely on the overall quality of the data will also be created from the encounter data. These quality reports will also depict accuracy and completeness at a volume and utilization level.

ASC X12N 835

As discussed above, and in Section 5, the Plan will receive an 835 for encounter data that has been processed through the MMIS if requested and arranged in advance. Adjustment reason code, adjustment amount, and adjustment quantity are returned via the CAS segment of loop 2110 if the service line fails MMIS encounter errors. CAS segments are also created for cutbacks to the submitted charge-for-fee schedule reductions, etc. All encounter data denials, including those that are repairable, are represented in the 835. TCNs are assigned by claim and can be located in the 835 specific to the encounter.

The list of electronic files or reports as indicated in the RFP, are to be submitted by the Plan and/or DHH. The format and/or layout requirements for each file or report are located in either this Guide, the Quality Companion Guide, or at a developmental stage. As the list may not be all inclusive, it is the Plans responsibility to ensure that all required files or reports, as stated in the RFP, are submitted to DHH in a timely manner.

Prior Authorization File (FI to DBP)

This file is a one-time file that contains a 2-year history of prior authorization and Pre-Admission Certification (Pre-cert) authorization transactions performed by the Louisiana Medicaid MMIS.

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	LA-MMIS assigned ID number	7	Numeric, non-check-digit.
8	Delimiter		1	Uses the ^ character value
9-15	Provider Check-Digit ID	LA-MMIS assigned ID number, check-digit	7	Numeric
16	Delimiter		1	Uses the ^ character value
17-29	Recipient ID (Original)		13	Numeric
30	Delimiter		1	Uses the ^ character value
31-43	Recipient ID (Current)		13	Numeric
44	Delimiter		1	Uses the ^ character value
45-54	NPI		10	Character
55	Delimiter		1	Uses the ^ character value
56	Taxonomy		10	Character
66	Delimiter		1	Uses the ^ character value
67-71	Procedure Code		5	Character, CPT or HCPCS value

Column(s)	Item	Notes	Length	Format
72	Delimiter		1	Uses the ^ character value
73	Authorized Units/Amount		10	Numeric, with decimal and left-zero fill
83	Delimiter		1	Uses the ^ character value
84-91	Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
92	Delimiter		1	Uses the ^ character value
93-100	Effective End Date		8	Numeric, date value in the format YYYYMMDD
101	Delimiter		1	Uses the ^ character value
102-106	Admitting Diagnosis Code (for Inpatient Pre-Admission Certification) or Diagnosis code if required on the PA		5	ICD-9-CM
107	Delimiter		1	Uses the ^ character value
108-111	Length of Stay in Days (for Inpatient Pre-Admission Certification)		4	Numeric, left zero-fill
112	Delimiter		1	Uses the ^ character value
113	PA or Precert Type	1=PA 2=Precert	1	Character

Column(s)	Item	Notes	Length	Format
114	Delimiter		1	Uses the ^ character value
115-116	PA Type Or Precert Type	**Precert**: 03=Inpatient Acute **PA**: 04=Waiver 05=Rehab 06=HH 07=Air EMT 09=DME 10=Dental 11=Dental 14=EPSDT-PCS 16=PDHC 35=ROW 40=RUM 50=LT-PCS 60=Early Steps CM 88=Hospice 99=Misc.	2	
117	Delimiter		1	Uses the ^ character value
118-119	PA or Precert Status	02=Approved 03=Denied	2	Character
120	Delimiter		1	Uses the ^ character value
121-125	Precert Level of	GEN	5	Character

Column(s)	Item	Notes	Length	Format
	Care (this field should be blank for PA transactions)	ICU NICU REHAB PICU CCU TU=Telemetry LT=LTAC		
126	Delimiter		1	Uses the ^ character value
127-136	PA Line Amount Used	For an approved PA or Precert line item, this field contains any amount used as a result of claims processing	10	Numeric, with decimal and left-zero fill.
137	Delimiter		1	Uses the ^ character value
138-147	PA or Precert Number assigned by Molina		10	9- or 10-digit number
148	Delimiter		1	Uses the ^ character value
149	End of Record		1	Value is spaces.

Diagnosis File for Pre-Admission Certification (FI to DBP)

This file shows all diagnosis codes applicable to the Inpatient Pre-Admission Certification (Pre-cert) operation with Louisiana Medicaid MMIS.

Column(s)	Item	Notes	Length	Format
1-5	Diagnosis Code		5	Character, does not include the period
6	Delimiter		1	Uses the ^ character value
7	Pre-Cert Status	1=Applicable 2=Not applicable	1	Numeric
8	Delimiter		1	Uses the ^ character value
9-16	Effective Begin Date		8	Numeric in date format YYYYMMDD
17	Delimiter		1	Uses the ^ character value
18-25	Effective End Date		8	Numeric in date format YYYYMMDD
26	Delimiter		1	Uses the ^ character value
27	End of Record		1	Value is spaces.

820 File (FI to DBP)

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
ST=Transaction Set Header					
Sample: ST*820*0001*005010X218~					
	ST	ST01	Transaction Set Identifier Code	'820'	S
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					
		ST02	Transaction Set Control Number		
Remark: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.					

		ST03	Implementation Convention Reference	'005010X218'	S
Remark: This element must be populated with the guide identifier named in Section 1.2 of the IG. The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X218. This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (STSE) processing. Providing the information from the SG08 at this level will ensure that the appropriate application mapping is utilized at transaction time.					

BPR=Financial Information					
Sample: BPR*I*1234567.89*C*ACH*CCP*01*123456789*DA*123456*1123456789**01*987654321*DA*654321*20120103~					
	BPR	BPR01	Transaction Handling Code	I=Remittance Information Only	S
		BPR02	Monetary Amount	Total Premium Payment Amount	D
		BPR03	Credit/Debit Flag Code	C=Credit	S
		BPR04	Payment Method Code	ACH=Automated Clearinghouse	S
		BPR05	Payment Format Code	CCP=CCD+ Format	S
		BPR06	(DFI) ID Number Qualifier	Depository Financial Institution (DFI) Identification Number Qualifier 01 – ABA Transit Routing Number Including Check Digits (9 digits)	S
Remark: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. SEMANTIC: BGN06 is the transaction set reference number of a previously sent transaction affected by the current transaction. SITUATIONAL RULE: Required when there is a previously sent transaction to cross-reference. If not required by this implementation guide, do not send.					
		BPR07	(DFI) Identification Number	ID number of originating Depository (DHH)	S
		BPR08	Account Number Qualifier	Code indicating type of account “DA”	S

				- Demand Deposit	
		BPR09	Account Number	Premium payer's bank account	S
		BPR10	Originating Company Identifier	Federal tax ID number preceded by a 1.	S
		BPR11	Originating Company Supplemental Code	NOT USED	
		BRP12	(DFI) ID Number Qualifier	Depository Financial Institution (DFI) Identification Number Qualifier "01" – ABA Transit Routing Number Including Check Digits	S
		BPR13	(DFI) Identification Number	This is the identifying number of the Receiving Depository Financial Institution receiving the transaction into the ACH network. (CCN)	S
		BRP14	Account Number Qualifier	Code indicating type of account "DA" - Demand Deposit "SG" - Savings	S
		BPR15	Account Number	CCN bank account number	
		BPR16	EFT Effective Date	Expressed CCYYMMDD	

TRN=Re-association Trace Number					
Sample: TRN*3*1123456789**~					
	TRN	TRN01	Trace Type Code	“3” – Financial Reassociation Trace Number. The payment and remittance information have been separated and need to be reassociated by the receiver.	S
		TRN02	Reference Identification	EFT Trace Number Used to reassociate payment with remittance information.	S
		TRN03	Originating Company Identifier	Must contain the Federal Tax ID number preceded by a 1 and must be identical to BPR10	S
REF=Premium Receiver’s Identification Key					
Sample: REF*18*123456789*CCN Fee Payment~					
		REF01	Reference Identification Qualifier	‘18’=Plan Number	S
		REF02	Reference Identification	Premium Receiver Reference Identifier	
		REF03	Description	‘CCN Fee Payment’	S

DTM=Process Date					
Sample: DTM*009*20120103~					
		DTM01	Date/Time Qualifier	“009” – Process	S
		DTM02	Date	Payer Process Date CCYYMMDD	S
DTM=Delivery Date					
Sample: DTM*035*20120103~					
		DTM01	Date/Time Qualifier	“035” – Delivered	S
		DTM02	Date	Payer Process Date CCYYMMDD	S
DTM=Report Period					
Sample: DTM*582****RD8*20120101-20120131~					
		DTM01	Date/Time Qualifier	“582” – Report Period	S
		DTM02	Not Used	Not Used	
		DTM03	Not Used	Not Used	
		DTM04	Not Used	Not Used	
		DTM05	Date Time Period Qualifier	‘RD8’	S
		DTM06	Date Time Period	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	D

1000A PREMIUM RECEIVER'S NAME					
N1=Premium Receiver's Name					
Sample: N1*PE*CCN-S of Louisiana*FI*1123456789~					
	1000A	N101	Entity ID Code	"PE" – Payee	
	1000A	N102	Name	Information Receiver Last or Organization Name	
	1000A	N103	Identification Code Qualifier	"FI" – Federal	
	1000A	N104	Identification Code	Receiver Identifier	
1000B PREMIUM PAYER'S NAME					
N1=Premium Payer's Name					
Sample: N1*PR*Louisiana Department of Health and Hospitals*FI*1123456789~					
	1000B	N101	Entity ID Code	"PR" – Payer	
	1000B	N102	Name	Premium Payer Name	
	1000B	N103	ID Code Qualifier	"FI" - Federal Taxpayer ID number	
	1000B	N104	Identification Code	Premium Payer ID	

2000B INDIVIDUAL REMITTANCE					
ENT=Individual Remittance					
Sample: ENT*1*2J*34*123456789~					
	2000B	ENT01	Assigned Number	Sequential Number assigned for differentiation within a transaction set	
	2000B	ENT02	Entity Identifier Code	“2J” - Individual	
	2000B	ENT03	Identification Code Qualifier	“34” - Social Security Number	
	2000B	ENT04	Identification Code	Individual Identifier - SSN	
2100B INDIVIDUAL NAME					
NM1=Policyholder Name					
Sample: NM1*QE*1*DOE*JOHN*Q***N*1234567890123~					
	2100B	NM101	Entity Identifier Code	“QE” - Policyholder (Recipient Name)	
	2100B	NM102	Policyholder	“1” - Person	
	2100B	NM103	Name Last	Individual Last Name	
	2100B	NM104	Name First	Individual First Name	

	2100B	NM105	Name Middle	Individual Middle Initial	
	2100B	NM106	NOT USED	NOT USED	
	2100B	NM107	NOT USED	NOT USED	
	2100B	NM108	Identification Code Qualifier	"N" – Individual Identifier	
	2100B	NM109	Identification Code	Individual Identifier – Recipient ID number	
2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL					
RMR=Organization Summary Remittance Detail					
Sample: RMR*11*1234567890123**400.00~					
	2300B	RMR01	Reference Identification Qualifier	"11" - Account Number	
	2300B	RMR02	Reference Identification	Claim ICN (Molina internal claims number).	
	2300B	RMR04	Monetary Amount	Detail Premium Payment Amount	
REF=Reference Information (1st occurrence)					
Sample: REF*ZZ*0101C~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	

	2300B	REF02	Reference Identification	Capitation Code	
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
DTM=Individual Coverage Period					
Sample: DTM*582****RD8*20120101-20120131~					
	2300B	DTM01	Date/Time Qualifier	"582" - Report Period	
	2300B	DTM02	NOT USED	NOT USED	
	2300B	DTM03	NOT USED	NOT USED	
	2300B	DTM04	NOT USED	NOT USED	
	2300B	DTM05	Date Time Period Format Qualifier	"RD8" – Range of Dates	
	2300B	DTM06	Date Time Period	Coverage Period, expressed as CCYYMMDD-CCYYMMDD	
Transaction Set Trailer					
Sample: SE*39*0001~					
	SE	SE01	Transaction Segment Count		
		SE02	Transaction Set Control Number		
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					

An adjustment of a previous original administrative fee payment will be shown as two 2300B sets: a void of the previous payment and a record showing the new adjusted amount. The void record will have RMR and ADX segments, where the RMR will have the original claim ICN in RMR02 and the original payment amount in RMR05. The ADX will have a negative amount (equal to the original payment) in ADX01 and the value '52' in ADX02. The record showing the new adjusted amount will behave in the same manner as an original payment (RMR). Here is an example of an adjustment set:

Void sequence (reversal of prior payment):

ENT*107*2J*ZZ*7787998022222~

NM1*QE*1*DOE*JOHN*D***N*1234567890123~

RMR*AZ*1059610021800***500~

ADX*-500*52~

Adjusted Amount sequence:

ENT*107*2J*ZZ*7787998022222~

NM1*QE*1*DOE*JOHN*D***N*1234567890123~

RMR*AZ*1067610041100**600~

REF*ZZ*0101C~ (added to comply with HIPAA standard)

DTM*582****RD8*20120201-20120229

Appendix E

Plan Generated Reports

The overarching purpose of this set of reports is to supplement information that is reported through the encounter process. Once the encounter process has stabilized, DHH may use encounters as the basis for these reports.

(DHH required version of the Plan generated reports are currently in the developmental stage and may be included in this Guide upon completion)

DENTAL BENEFIT PLAN REPORT GRID

MONTHLY
Post Payment Recoveries (existence of TPL)- M
Member Service Call Center M
Marketing and Member Education Materials Distributed- M
Grievance, Appeal and Fair Hearing Log- M
Claims Payment Accuracy Report- M
Denied Claims Report- M
Provider Call Center- M
Provider Complaint & Appeal Summary Report- M
QAPI Early Warning System Performance Measures- M
Claims Payment Summary - M
QUARTERLY
EPSDT Report (CMS 416)- Q/A
UM Committee Meeting Minutes- Q
Utilization Management Medical Record Review Report- Q

QAPI PCP Profile Reports- Q
PCD Linkages- Q
Grievance, Appeal and Fair Hearing Log
Grievance, Appeal and Fair Hearing Log (redacted Q/A)
QAPI Committee (minutes)- Q
Member Advisory Council (minutes)- Q
Fraud and Abuse Activity Report- Q
Claims Processing Interest Payments- Q
PA Summary- Q
Network Adequacy Review- Q
ANNUAL
Key Staff Organizational Listing- A
Functional Organizational Chart-Location Listing and Key Staff Job Description-A
NW Provider Development Management Plan - A
Utilization Management Dental Record Review Strategy- A
Marketing Activities Annual Review- A
QAPI Program Description and Work Plan- A
QAPI Performance Reporting Measures -** Template not provided. Will accept Health Plans' corporate standard.*
QAPI Performance Improvement Projects (descriptions)- A
QAPI Performance Improvement Projects (outcomes)- A
Member Satisfaction Survey Report A

Provider Satisfaction Survey Report- A
Systems Refresh Plan- A
Emergency Management Plan- A
Back-up File List- A
Annual Audited Financial Statement- A
Independent-Subcontractor EDP Audit (SSAE16)- A
QAPI Impact and Effectiveness of QAPI Program Evaluation- A

Appendix F

Encounter Edit Codes

In order for data to be useful, the data must meet minimum thresholds of data quality. One of the most basic tests of data quality is editing. All encounter data submitted to the MMIS are subject to edits. Edits may post at the line or at the header. If an encounter denies at the header, the encounter must be corrected and resubmitted.

Encounter data edits can have one of the following dispositions:

- Encounter passes all edits and is accepted into the MMIS per DHH guidelines,
- Encounter contains a fatal error that results in its Denial.

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
1	20140701	D	INVALID CLM TYP MOD	INVALID CLAIM TYPE MODIFIER
2	20140701	D	INVALID PROVIDER NO	PROVIDER NUMBER MISSING OR NOT NUMERIC
3	20140701	D	RECIPIENT # INVALID	RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS
5	20140701	D	INVAL SERV FROM DATE	SERVICE FROM DATE MISSING/INVALID
6	20140701	D	INVAL SERV THRU DATE	INVALID OR MISSING THRU DATE
7	20140701	D	SERV THRU LT SERV FM	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
8	20140701	D	SERV FRM GT ENTR DTE	SERVICE FROM DATE LATER THAN DATE PROCESSED

9	20140701	D	SERV THR GT ENTR DTE	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
13	20140701	D	ORG CLM W ADJ/VD ICN	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID ICN
15	20140701	D	INVALID ACCIDENT IND	ACCIDENT INDICATOR MUST BE Y,N,SPACE
16	20140701	D	INVALID ACCID IND	ACCIDENT INDICATOR NOT Y, N OR SPACE
17	20140701	D	INVALID EPSDT IND	EPSDT INDICATOR NOT Y, N, OR SPACE
20	20140701	D	INVAL/MISS DIAG CODE	INVALID OR MISSING DIAGNOSIS CODE
21	20140701	D	INVALID FORMER REFNO	FORMER REFERENCE NUMBER MISSING OR INVALID
22	20140701	E	INVALID BILLED CHRGS	BILLED CHARGES MISSING OR NOT NUMERIC
23	20140701	D	INV PARTIAL RECIP	RECIPIENT NAME IS MISSING
24	20140701	D	INV BILLING PROV NO	BILLING PROVIDER NUMBER NOT NUMERIC
30	20140701	E	SERV THRU DT TOO OLD	SERV THRU DATE MORE THAN TWO YEARS OLD
35	20140701	D	REBILL CORRECT HCPC_	ASC,OP FAC/PHYS.BILLED DIFF CODE;REBILL CORRECT HCPC
40	20140701	D	INV ADMISSION DATE	ADMISSION DATE MISSING OR INVALID
43	20140701	D	INV ATTENDING PHYS	ATTENDING PHYSICIAN NUMBER NOT NUMERIC
44	20140701	E	INV NATURE OF ADMIT	NATURE OF ADMISSION MISSING OR INVALID
45	20140701	D	INV PATIENT STATUS	PATIENT STATUS CODE INVALID OR MISSING
46	20140701	D	INV PATIENT STAT DTE	PATIENT STATUS DATE MISSING OR INVALID

47	20140701	D	PAT STAT DTE GT THRU	PATIENT STATUS DATE GREATER THAN THRU DATE
48	20140701	D	INVALID/MISS PROC	INVALID OR MISSING PROCEDURE CODE
49	20140701	D	INV/CONFLIC SURG DTE	INVALID/CONFLICT SURGICAL DATE
53	20140701	E	INV ACCOMODATION DAY	ACCOMODATION DAYS MISSING OR INVALID
55	20140701	E	INV ACCOM/ANCILL CHG	ACCOMODATION/ANCILLARY CHARGE MISSING OR INVALID
60	20140701	E	INVALID COVERED DAYS	COVERED HOSPITAL DAYS NOT NUMERIC OR MISSING
63	20140701	E	INVALID TOTAL CHARGE	THE TOTAL HOSPITAL CHARGE IS NOT NUMERIC
64	20140701	E	INVALID NET AMOUNT	THE NET BILLED AMOUNT IS NOT NUMERIC
67	20140701	E	INVALID NON-COVERED	NON COVERED HOSP DAYS NOT NUMERIC OR MISSING
68	20140701	E	INV POINT ORIGIN	INVALID POINT OF ORIGIN
69	20140701	D	INV OCCUR DATE	INVALID OCCURRENCE DATE
71	20140701	D	INV STMT COVERS FROM	STATEMENT COVERS FROM DATE INVALID
72	20140701	D	INV STMT COVER THRU	STATEMENT COVERS THRU DATE INVALID
73	20140701	D	STMT FRM LT SERV FRM	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM DATE
74	20140701	D	STMT THRU GT SRV THR	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE THRU
81	20140701	D	INVALID STATUS DATE	INVALID OR MISSING PATIENT STATUS DATE
82	20140701	D	INVALID STATUS CODE	INVALID PATIENT STATUS CODE

84	20140701	E	INVALID TREAT PLACE	INVALID OR MISSING PLACE OF TREATMENT
93	20140701	E	REVENUE CODE MISSING	REVENUE CODE MISSING/INVALID
94	20140701	D	MISSING PINTS BLOOD	MISSING PINTS BLOOD
97	20140701	E	NON-COVCHG > BILLCHG	NON-COVERED CHARGES EXCEED BILLED CHARGES
102	20140701	D	INVALID SURFACE	INVALID TOOTH SURFACE CODE
103	20140701	D	INV TOOTH/CAVITY CDE	INVALID TOOTH CODE/ORAL CAVITY DESIGNATOR
108	20140701	E	PRV TYPE AGE RESTRIC	PROV TYPE SERVICES NOT COVERED FOR RECIPIENT THIS AGE
115	20140701	E	HCPC CD NOT ON FILE	HCPC CODE NOT ON FILE
120	20140701	D	QTY INVALID/MISSING	QUANTITY INVALID/MISSING
127	20140701	D	MISSING NDC	NDC CODE MISSING OR INCORRECT.
130	20140701	D	DENY PROV. 9999999	ALL PROVIDERS 9999999 TO BE DENY.
131	20140701	D	PRIMARY DX NOF	PRIMARY DIAGNOSIS NOT ON FILE
132	20140701	E	SECONDARY DX NOF	SECONDARY DIAGNOSIS NOT ON FILE
134	20140701	D	ENC DENIED BY PLAN	DENIED ENCOUNTER SUBMITTED BY PLAN
136	20140701	E	NO ELIG SERVICE PAID	NO ELIGIBLE SERVICE PAID - ENCOUNTER DENIED
141	20140701	D	REFILL OVR 12 MONTHS	REFILL NOT FILLED WITHIN 12 MONTHS
180	20140701	D	INVALID ADMIT DATE	THE ADMISSION DATE WAS NOT A VALID DATE
183	20140701	D	SURGERY PROC NOF	SURGICAL PROCEDURE NOT ON FILE

186	20140701	D	USE CORRECT MODIFIER	CRNA'S MUST BILL CORRECT MODIFIER
200	20140701	D	PROV/ATTEND NOF	PROVIDER/ATTENDING PROVIDER NOT ON FILE
201	20140701	D	PROVIDER NOT ELIG	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
202	20140701	D	PROV CLAIM TYP CONFL	PROVIDER CANNOT SUBMIT THIS TYPE CLAIM
203	20140701	E	PROVIDER ON REVIEW	PROVIDER ON REVIEW
206	20140701	D	BILL PROV NOT ON FIL	BILLING PROVIDER NOT ON FILE
210	20140701	E	PROV PROC CONFLICT	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
211	20140701	D	DOS LESS THAN DOB	DATE OF SERVICE LESS THAN DATE OF BIRTH
215	20140701	D	RECIPIENT NOT ON FIL	RECIPIENT NOT ON FILE
216	20140701	D	RECIPIENT NOT ELIG	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE
217	20140701	E	RECIP NAME MISMATCH	NAME AND/OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD
222	20140701	D	SVC OVERLAPS REC ELI	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S)
223	20140701	D	RECYC RECIP N/O FILE	RECYCLED RECIPIENT NOT 0N FILE
231	20140701	E	NDC NOT ON P/F FILE	NDC CODE NOT ON FILE
232	20140701	E	PROCEDURE CODE NOF	PROCEDURE/TYPE OF SERVICE NOT COVERED BY PROGRAM
233	20140701	E	P/F DATE RESTRICTION	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN
234	20140701	E	P/F AGE RESTRICTION	P/F AGE RESTRICTION

235	20140701	E	P/F SEX RESTRICTION	P/F SEX RESTRICTION
237	20140701	E	P/F PROV SPEC RESTRT	P/F PROVIDER SPECIALTY RESTRICTION
248	20140701	D	DELETED,BILL CURR CD	DELETED,BILL CURRENT CODE
252	20140701	D	DIAGNOSIS NOT ON FIL	DIAGNOSIS NOT ON FILE
254	20140701	E	DIAG AGE RESTRICTION	DIAGNOSIS AGE RESTRICTION
255	20140701	E	DIAG SEX RESTRICTION	DIAG SEX RESTRICTION
258	20140701	D	SPAN DATES/QUANT DIF	DIFFERENCE BETWEEN SERVICE DATES AND QUANT
263	20140701	E	PROCEDURE-AGE-RESTRT	PROCEDURE ALLOWED FOR RECIP 0-30 DAYS OLD
266	20140701	D	INVALID AMB SURG REV	REV CODE INVALID FOR AMBULATORY SURG PROC.
267	20140701	D	REQ-ICD9-SURGICAL-CD	REVENUE CODE 490 REQUIRES VALID ICD9 SURGICAL PROCEDURE
272	20140701	E	CLAIM OVER 1 YEAR	CLAIM EXCEEDS 1 YEAR FILING LIMIT
273	20140701	E	TPL/PRIVATE	3RD PARTY CARRIER CODE MISSING-REFER TO CARRIER CD.LIST
275	20140701	E	RECIP MEDICARE ELIG	RECIPIENT IS MEDICARE ELIGIBLE
278	20140701	E	RECIP ELIG MEDICARE	RECIPIENT POSSIBLY ELIGIBLE FOR MEDICARE
279	20140701	E	PROF COMP INVLD POT	INVALID PLACE OF TREATMENT FOR PROF COMP

289	20140701	D	INV DENY FOR PROV NO	INVALID PROVIDER NUMBER WHEN DENY APPLIED
295	20140701	D	RECIP RECYC 3 TIMES.	RECIPIENT INELIGIBLE RECYCLED THREE TIMES
299	20140701	E	PROC/DRUG NOTCOVERED	PROC/DRUG NOT COVERED BY MEDICAID
304	20140701	D	NOT USED - AVAILABLE	NOT USED - AVAILABLE
307	20140701	D	SURG PROC MISSING	SURGICAL PROCEDURE MISSING
309	20140701	D	SURG DATE MISSING	DATE OF SURGERY MISSING
310	20140701	D	SURG DTE LT SRV FROM	DATE OF SURGERY LESS THAN SERVICE FROM DATE
318	20140701	D	SUSP CON MIS/REQ-RF2	SUSPECTED CONDITION MISSING AND REQUIRED FOR REFERRAL 2
319	20140701	D	SUSP CON MIS/REQ-RF3	SUSPECTED CONDITION MISSING REQUIRED FOR REFERRAL 3
329	20140701	E	CLIA NOT CERT DOS	CLIA # DOES NOT COVER DATE OF SERVICE
330	20140701	D	QMB NOT MED. ELIG.	QMB NOT MEDICAID ELIGIBLE
339	20140701	D	OCCUR DATES CONFLICT	OCCUR CODES/DATES CONFLICT
340	20140701	E	SPAN DAYS CONFLICT	SPAN DAYS/NON COVERED DAYS CONFLICT
349	20140701	D	INVALID TYPE CASE	RECIPIENT NOT COVERED FOR THIS SERVICE
364	20140701	D	RECIP INELIG/DECEASE	RECIPIENT INELIGIBLE/DECEASED
386	20140701	E	NOT PAY W/CLIA CERT	NOT PAYABLE WITH CLIA CERT TYPE
387	20140701	E	CLIA # NOT ON FILE	NO CLIA # ON OUR FILE
400	20140701	D	REFER PHYSICIAN REQD	REFERRING/ATTENDING PHYSICIAN REQUIRED

401	20140701	E	CONCURRENT CARE	CONCURRENT CARE IS NOT COVERED BY THE PROGRAM
410	20140701	E	ENC LICN PREFIX ERROR	LICN PREFIX ON ENCOUNTER IS MISSING OR INVALID
414	20140701	E	ENC PLAN PMT DT ERR	PLAN PAYMENT DATE ON ENCOUNTER IS MISSING OR INVALID
416	20140701	E	ENC RCV DT ERROR	PLAN RECEIVE DATE ON ENCOUNTER IS MISSING OR INVALID
417	20140701	E	ENC INT PMT ERROR	INTEREST PAYMENT ON PLAN ENCOUNTER IS INVALID
433	20140701	D	MISSING/INVALID DIAG	MISSING/INVALID DIAGNOSIS CODE
444	20140701	D	M/I SERVICE PROVIDER	MISSING/INVALID SERVICE PROVIDER
475	20140701	E	QW MODIFIER NEEDED	QW MODIFIER NEEDED FOR TYPE OF CLIA CERTIFICATE
506	20140701	D	SUB PROV NON PAR BYU	SUBMIT TO RECIPIENTS SHARED PLAN
513	20140701	D	HCPCS REQ	HCPCS REQUIRED
522	20140701	E	MOTH/NEWBRN BILL SEP	MOTHER/NEWBORN MUST BE BILLED SEPARATE
539	20140701	E	CLAIM REQ DETAIL	CLAIM REQUIRES DETAILED BILLING
544	20140701	D	CT NOT COV FPW	CLAIM TYPE/FORMAT NOT COVERED BY THE FPW PROGRAM
545	20140701	D	REV CODE INVALID NDC	REVENUE CODE INVALID FOR REPORTING NDC INFO
550	20140701	E	NO MULTI - PROVIDERS	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE
556	20140701	E	ATND PRV NOT LNK BYU	ATTENDING/SERVICING PROVIDER NOT LINKED TO BYU PLAN

563	20140701	D	ADJ-ADD-ON-WITH-51	ADJ ADD-ON CODE WITH 51 MOD THEN REBILL PRIMARY PROC
578	20140701	E	INV POS/MOD COMBO	INVALID PLACE OF SERVICE/PROCEDURE MODIFIER COMBINATION
601	20140701	D	ADULT DENTAL-UNDER21	ADULT DENTAL CLAIM FILED FOR RECIP UNDER 21
602	20140701	E	SURFACE CODE CONF	CLAIM DOES NOT INDICATE CORRECT NUMBER OF SURFACES
603	20140701	E	TOOTH/CAVITY CDE REQ	TOOTH CODE/ORAL CAVITY DESIGNATOR REQUIRED
604	20140701	D	EPSDT DENT AGE GR 21	EPSDT DENTAL CLAIM - RECIPIENT AGE GREATER THAN 21
613	20140701	D	INV TOOTH/CAVITY CDE	INVALID TOOTH CODE/ORAL CAVITY DESIGNATOR
618	20140701	E	URINALYSIS NOT BILLE	URINEALYSIS BILLED INCORRECTLY
631	20140701	D	EPSDT AGE ERROR	EPSDT AGE OVER 21
644	20140701	D	VISIT CODE PD/DOS	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
663	20140701	E	NO ABORTION DONE	ABORTION NOT DONE-FETUS NOT ALIVE AT TIME OF PROCEDURE
673	20140701	D	EVAL & MGT PD DOS	EVAL AND MGT CODE PAID FOR THIS DOS
675	20140701	D	VACCINE/ADM CONFLICT	VACC & ADM MUST PAY/AGREE;IF ONLY ONE PAYS TOTAL DENIES
676	20140701	D	PRIMARY CODE DENIED	PAYABLE ONLY IF PRIMARY CODE IS PAID
678	20140701	E	GLOBAL CODE PD	GLOBAL CODE PD THIS DOS THIS RECIP
679	20140701	E	COMPONENT CODE PD	COMPONENT CODE PD THIS DOS RECIP

680	20140701	E	ABORT PD MOTHER LIFE	ABORTION PAID MOTHERS LIFE ENDANGERED
695	20140701	D	HOSP DISCHARGE PAID	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
702	20140701	D	NEW PT/EST PT CD CON	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
704	20140701	D	ER VISIT/INP HOS SER	ER VISIT ON DATE OF INP HOS SERVICES
706	20140701	D	SEPARATE NB CARE CHG	FOLLOWUP NB CARE BILLED SEPARATELY
711	20140701	E	SAME SPEC/SUBSP PAID	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF SERV
712	20140701	D	INITIAL HOSP INPT PD	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS
715	20140701	E	2ND. VISIT SAME DAY	FOUND DUPLICATE VISIT SAME DAY
716	20140701	D	PROC INCLUDED IN OV	PROCEDURE INCLUDED IN THE PHYSICIAN VISIT
720	20140701	D	TO BE BILLED BY PROV	MUST BE BILLED BY PROVIDER OF SERVICE
721	20140701	E	SUR ASST NOT NEEDED	PROCEDURE DOES NOT WARRANT SURGICAL ASSIST
735	20140701	D	PREV PD ANES-SAME RE	PREVIOUSLY PAID ANES.OR SUPERVISING ANES,SAME RECI/DOS
746	20140701	D	SAME ATTD PD IP CONS	SAME ATTENDING PROV PAID INPT CONSULTATION SAME STAY
748	20140701	D	1 DEL.ALLOW. 6MTH.SP	ONLY 1 DELIVERY ALLOWED IN 6 MONTH SPAN
749	20140701	D	DEL HYST/STER CONFLI	DELIVERY BILLED AFTER HYSTERECTOMY/STERLIZ WAS DONE
750	20140701	E	STERILIZATION	FOUND PROC. 2 X INDICATES

			INDIC_	STERILIZATION
753	20140701	D	REBILL-DELIVERY	REBILL DELIVERY (DELIVERY-SURGERY) CODE & OFFICE VISIT
755	20140701	D	BILL AS ADJ/CNT STAY	THIS SHOULD BE BILLED AS ADJUST.FOR CNT STAY
757	20140701	D	ADJ PD LINE 51 MOD	ADJUST PAID LINE WITH 51 MODIFIER THEN RESUBMIT MAJOR
758	20140701	D	FND DUP SERV SM DAY	FOUND DUPLICATE SERVICE SAME DAY
777	20140701	E	ABORTION RAPE-PAID	ABORTION DUE TO RAPE PAID
781	20140701	E	MODIFIER NOT CORRECT	INAPPROPRIATE PROCEDURE CODE MODIFIER-REBILL
789	20140701	E	ABORTION INCEST-PAID	ABORTION DUE TO INCEST PAID
794	20140701	D	INPT SER PD SAME ATT	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV
796	20140701	D	ORIG/ADJ PROV DIFF	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
797	20140701	D	DUP ADJ. RECORD	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	20140701	D	HIST ALREADY ADJSTED	HISTORY RECORD ALREADY ADJUSTED
799	20140701	D	NO ADJ HISTORY	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
800	20140701	D	ON-LINE DUPE DENY	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	20140701	D	EXACT DUPE 01 TO 01	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
805	20140701	D	EXACT DUPE 03 TO 03	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	20140701	D	EXACT DUPE 03 TO 05	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES

807	20140701	D	EXACT DUPE 03 TO 06	EXACT DUPLICATE ERROR: OUTPATIENT AND HOME HEALTH
808	20140701	D	EXACT DUPE 03 TO 07	EXACT DUPLICATE ERROR: OUTPATIENT AND AMBULANCE
810	20140701	D	EXACT DUPE 03 TO 09	EXACT DUPLICATE ERROR: OUTPATIENT AND DURABLE-EQUIPMENT
813	20140701	E	EXACT DUPE 04 TO 04	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
815	20140701	E	EXACT DUPE 05 TO 05	EXACT DUPLICATE ERROR: IDENTICAL REHAB-SERVICES CLAIMS
816	20140701	D	EXACT DUPE 05 TO 06	EXACT DUPLICATE ERROR: REHAB-SERVICES AND HOME HEALTH
817	20140701	D	EXACT DUPE 05 TO 07	EXACT DUPLICATE ERROR: REHAB-SERVICES AND AMBULANCE
818	20140701	D	EXACT DUPE 05 TO 08	EXACT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMBULANCE
819	20140701	D	EXACT DUPE 05 TO 09	EXACT DUPLICATE ERROR: REHAB-SERVICES AND DURABLE EQUIP
822	20140701	D	EXACT DUPE 06 TO 06	EXACT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAIMS
823	20140701	D	EXACT DUPE 06 TO 07	EXACT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE
828	20140701	D	EXACT DUPE 07 TO 07	EXACT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS
830	20140701	D	EXACT DUPE 07 TO 09	EXACT DUPLICATE ERROR: AMBULANCE AND DURABLE-EQUIP
833	20140701	D	EXACT DUPE 08 TO 08	EXACT DUPLICATE ERROR: IDENTICAL NON-AMBULANCE CLAIMS

837	20140701	D	EXACT DUPE 09 TO 09	EXACT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP CLAIMS
843	20140701	D	EXACT DUPE 12 TO 12	EXACT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS
849	20140701	D	PD SAME ATTEN/DIF BL	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER
851	20140701	E	SUSPCT DUPE 01 TO 01	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	20140701	E	SUSPCT DUPE 03 TO 03	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
857	20140701	E	SUSPCT DUPE 01 TO 06	SUSPCT DUPLICATE ERROR: OUTPATIENT AND HOME-HEALTH
859	20140701	E	SUSPCT DUPE 03 TO 08	SUSPCT DUPLICATE ERROR: OUTPATIENT AND NON-AMBULANCE
860	20140701	E	ENCOUNTER COB ERROR	FIRST COB LOOP ON ENCOUNTERS IS INVALID (NOT PLAN PAYER ID)
863	20140701	E	SUSPCT DUPE 04 TO 04	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
865	20140701	E	SUSPCT DUPE 05 TO 05	SUSPEC DUPLICATE ERROR: IDENTICAL REHAB-SERVICES CLAIMS
866	20140701	E	SUSPCT DUPE 05 TO 06	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND HOME HEALTH
867	20140701	E	SUSPCT DUPE 05 TO 07	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND AMBULANCE
868	20140701	E	SUSPCT DUPE 05 TO 08	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMBULANC

869	20140701	E	SUSPCT DUPE 05 TO 09	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND DME
872	20140701	E	SUSPCT DUPE 06 TO 06	SUSPCT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAIMS
873	20140701	E	SUSPCT DUPE 06 TO 07	SUSPCT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE
874	20140701	E	SUSPCT DUPE 06 TO 08	SUSPCT DUPLICATE ERROR: HOME HEALTH AND NON-AMBULANCE
878	20140701	E	SUSPCT DUPE 07 TO 07	SUSPCT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS
879	20140701	E	SUSPCT DUPE 07 TO 08	SUSPCT DUPLICATE ERROR: AMBULANCE AND NON-AMBULANCE
884	20140701	E	SUSPCT DUPE 08 TO 09	SUSPECT DUPLICATE ERROR: NON-AMBULANCE AND DME CLAIMS
887	20140701	E	SUSPCT DUPE 09 TO 09	SUSPECT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP CLAIMS
893	20140701	E	SUSPCT DUPE 12 TO 12	SUSPECT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS
898	20140701	D	EXACT DUPE SAME ICN	EXACT DUPE SAME ICN - DROPPED
900	20140701	D	LIFETIME LIMITS-ONE	ONLY 1 NEWBORN HOSPITAL CARE PER RECIPIENT ALLOWED
924	20140701	E	EFF 11/5/10 NDC REQU	EFF 11/5/10 PAS FOR THIS HCPC REQUIRES CORRECT NDC CODE
931	20140701	E	DENIED PER TPL EOB	DENIED PER THE TPL EOB INFORMATION
946	20140701	E	SPLIT BILL FOR PART.	SPLIT BILL FOR PARTIAL ELIGIBILITY.
948	20140701	E	INC IN MAJ SUR PROC	INCLUDED IN MAJOR SURGICAL PROCEDURE

951	20140701	E	DISCH DATE NOT COV	DATE OF DISCHARGE NOT COVERED
952	20140701	E	INC IN OV/RELAT PROC	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE
957	20140701	E	PROC/DIAG NO MED NEC	PROCEDURE/DIAGNOSIS NOT MEDICALLY NECESSARY
970	20140701	D	INAPPROPRIATE CODE,	INAPPROPRIATE CODE, BILL LAB OR SPECIFIC HANDLING.
973	20140701	E	NO SURGERY MODIFIER	CLAIM DESCRIPT INDICATES PROC CODE SHOULD HAVE MODIFIER
980	20140701	E	INVALID ADJ REASON	INVALID ADJUSTMENT REASON
983	20140701	D	SYS CALC NET TOTAL	SYSTEM CALCULATED TOTAL - NET BILLED NOT IN BALANCE
991	20140701	E	PROCEDURE IN PANEL	PROCEDURE INCLUDED IN PANEL

Appendix G

Provider Directory/Network Provider and Subcontractor Registry

The Plan is required to provide an adequate network of providers in sufficient numbers and locations to provide required access to covered services. The plan must make sure that there is adequate provider network access to covered services that meets standards of distance, timeliness, amount, duration and scope as defined in the contract with DHH for the members. Plans are required to provide DHH with a listing of all contracted providers. Providers in the Plans' network are not required to be enrolled in Louisiana Medicaid, but all are required to be included in the listing submitted to DHH.

At the onset of the contract and periodically as changes are necessary, DHH shall publish a list of NPIs of Medicaid providers that will include provider types, specialty, and sub-specialty coding schemes to the Plan and or its contractor. The Plan and/or its contractor shall utilize these codes within their provider file record, at the individual provider level. The objective is to coordinate the provider enrollment records of the Plan with the same provider type, specialty and sub-specialty codes as those used by DHH and the Enrollment Broker.

The Plan listing of contracted providers is to be submitted electronically through the state's Fiscal Intermediary (FI). Only one unique record per combined NPI and Taxonomy should be submitted in the master Provider Registry.

Many of the data elements are publicly available from NPPES through the Freedom of Information Act (FOIA). Any providers no longer taking patients must be clearly identified. Under the FOIA, CMS allowed disclosure of NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry became operational on September 4th and CMS posted the downloadable file on September 12th, 2007. The complete listing of data elements and file specifications are detailed in this Appendix.

It is the Plan's responsibility to ensure the completeness and accuracy of the data submitted. Any providers no longer taking patients must be clearly identified. Updates to the registry, must be submitted by the Plans at least monthly, but can be updated weekly. The FI will process all updates submitted by 5:00 p.m. (CDT) each Friday.

The Plan is required to populate the Provider Type field to a DHH valid provider type code as shown in the list below:

Provider Type	
	Description
07	Case Mgmt - Infants & Toddlers
08	Case Mgmt - Elderly
09	Hospice Services
12	Multi-Systemic Therapy
13	Pre-Vocational Habilitation
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS)
25	Mobile X-Ray/Radiation Therapy Center
26	Pharmacy

Provider Type

	Description
27	Dentist or Dental Group
28	Optometrist and Optometrist Group
29	Title V Part C Agency Services(EarlySteps)
30	Chiropractor and Chiropractor Group
31	Psychologist
32	Podiatrist and Podiatrist Group
34	Audiologist
35	Physical Therapist
37	Occupational Therapist
39	Speech Therapist
40	DME Provider
41	Registered Dietician
42	Non-Emergency Medical Transportation
43	Case Mgmt - Nurse Home Visit - 1st Time Mother
44	Home Health Agency
46	Case Mgmt - HIV
51	Ambulance Transportation
54	Ambulatory Surgery Center
55	Emergency Access Hospital
57	OPH Public Health Registered Nurse

Provider Type

	Description
59	Neurological Rehabilitation Unit (Hospital)
60	Hospital
61	Venereal Disease Clinic
62	Tuberculosis Clinic
64	Mental Health Hospital Freestanding
65	Rehabilitation Center
66	KIDMED Screening Clinic
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
69	Hospital – Distinct Part Psychiatric
69	Hospital - Distinct Part Psychiatric Unit
70	EPSDT Health Services
71	Family Planning Clinic
72	Federally Qualified Health Center
73	Social Worker
74	Mental Health Clinic
75	Optical Supplier
76	Hemodialysis Center
77	Mental Health Rehabilitation
78	Nurse Practitioner

Provider Type

	Description
79	Rural Health Clinic (Provider Based)
80	Nursing Facility
81	Case Mgmt - Ventilator Assisted Care Program
87	Rural Health Clinic (Independent)
88	ICF/DD - Group Home
90	Nurse-Midwife
91	CRNA or CRNA Group
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan "638" Facilities
96	Psychiatric Residential Treatment Facility
97	Residential Care
AS	OPH Public Health Clinic
AU	Public Health Registered Dietitian

For providers registered as individual practitioners, DHH will also require the PLAN to assign a DHH provider specialty code from the DHH valid list of specialties found below:

Provider Specialty	Description	Associated Provider Types
01	General Practice	19,20
02	General Surgery	19,20,93
03	Allergy	19,20
04	Otology, Laryngology, Rhinology	19,20
05	Anesthesiology	19,20,91
06	Cardiovascular Disease	19,20
07	Dermatology	19,20
08	Family Practice	19,20,78
09	Gynecology (DO only)	19

Provider Specialty	Description	Associated Provider Types
10	Gastroenterology	19,20
12	Manipulative Therapy (DO only)	19
13	Neurology	19,20
14	Neurological Surgery	19,20
15	Obstetrics (DO only)	19
16	OB/GYN	19,20,78,90
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	19
18	Ophthalmology	20
19	Orthodontist	19,20
20	Orthopedic Surgery	19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	19
22	Pathology	20
23	Peripheral Vascular Disease or Surgery (DO only)	19
24	Plastic Surgery	19,20
25	Physical Medicine Rehabilitation	19,20
26	Psychiatry	19,20,93
27	Psychiatry; Neurology	19

Provider Specialty	Description	Associated Provider Types
	(DO only)	
28	Proctology	19,20
29	Pulmonary Diseases	19,20
30	Radiology	19,20
31	Roentgenology, Radiology (DO only)	19
32	Radiation Therapy (DO only)	19
33	Thoracic Surgery	19,20
34	Urology	19,20
35	Chiropractor	30,35
36	Pre-Vocational Habilitation	13
37	Pediatrics	19,20,93
38	Geriatrics	19,20
39	Nephrology	19,20
40	Hand Surgery	19,20
41	Internal Medicine	19,20
42	Federally Qualified Health Centers	72
44	Public Health	66,70
45	NEMT - Non-profit	42
46	NEMT - Profit	42
47	NEMT - F+F	42

Provider Specialty	Description	Associated Provider Types
48	Podiatry - Surgical Chiropody	20,32
49	Miscellaneous (Admin. Medicine)	20
51	Med Supply / Certified Orthotist	40
52	Med Supply / Certified Prosthetist	40
53	Med Supply / Certified Prosthetist Orthotist	40
54	Med Supply / Not Included in 51, 52, 53	40
55	Indiv Certified Orthotist	40
56	Indiv Certified Protherist	40
57	Indiv Certified Protherist - Orthotist	40
58	Indiv Not Included in 55, 56, 57	40
59	Ambulance Service Supplier, Private	51
60	Public Health or Welfare Agencies & Clinics	57,61,62,66,67,AU
62	Psychologist	29,31

Provider Specialty	Description	Associated Provider Types
	Crossovers only	
63	Portable X-Ray Supplier (Billing Independently)	25
64	Audiologist (Billing Independently)	29,34
65	Indiv Physical Therapist	29,35
66	Dentist, DDS, DMS	27
67	Oral Surgeon - Dental	27
68	Pedodontist	27
69	Independent Laboratory (Billing Independently)	23
70	Clinic or Other Group Practice	19,20,68,74,76,AS
71	Speech Therapy	29
72	Diagnostic Laboratory	23
73	Social Worker Enrollment	73
74	Occupational Therapy	29,37
75	Other Medical Care	65
76	Adult Day Care	85
77	Habilitation	85
78	Mental Health Rehab	77

Provider Specialty	Description	Associated Provider Types
79	Nurse Practitioner	78
81	Case Management	07,08,43,46,81
83	Respite Care	83
85	Extended Care Hospital	60
86	Hospitals and Nursing Homes	55,59,60,64,69,80,88
87	All Other	26,40,44
88	Optician / Optometrist	28,75
93	Hospice Service for Dual Elig.	09
94	Rural Health Clinic	79,87
95	Psychologist (PBS Program Only)	31
96	Psychologist (PBS Program and X-Overs)	31
97	Family Planning Clinic	71
1T	Emergency Medicine	19,20
2R	Physician Assistant	94
2T	American Indian/Native Alaskan	95
4R	Registered Dietician	41
5B	PCS-EPSDT	24
5C	PAS	24

Provider Specialty	Description	Associated Provider Types
5F	PCS-EPSDT, PAS	24
5H	Community Mental Health Center	18
5M	Multi-Systemic Therapy	12
6A	Psychologist -Clinical	31
6B	Psychologist-Counseling	31
6C	Psychologist - School	31
6D	Psychologist - Developmental	31
6E	Psychologist - Non-Declared	31
6F	Psychologist - All Other	31
6N	Endodontist	27
6P	Periodontist	27
7A	SBHC - NP - Part Time - less than 20 hrs week	38
7B	SBHC - NP - Full Time - 20 or more hrs week	38
7C	SBHC - MD - Part Time - less than 20 hrs week	38
7D	SBHC - MD - Full	38

Provider Specialty	Description	Associated Provider Types
	Time - 20 or more hrs week	
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	38
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	38
9B	Psychiatric Residential Treatment Facility	96
9D	Residential Care	97

PLAN must submit this information in the file layout shown below.

Dental Benefit Program Provider Registry File Layout

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
NOTE: This record format describes a fixed-format layout. The record size is fixed at 750 bytes. If a field is listed as Optional (O), and the DBP elects not to populate the field, then it should be filled with blanks or zeros as appropriate to the Length and Format definition (character or numeric, respectively).					
1-20	NPI	National Provider ID number	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to include them.	R
21	Delimiter		1	Character, use the ^ character value	
22	Entity Type code	**1**=Individual, **2**=Organization	1		R
23	Delimiter		1	Character, use the ^ character value	
24-43	Replacement NPI	DO NOT USE AT THIS TIME. FOR FUTURE USE.	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to use them.	O
44	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
45-74	Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), OR the Legal Business Name for Organizations)		30	Character	R
75	Delimiter		1	Character, use the ^ character value	
76-105	Provider Business Mailing Address (First line address)		30	Character	R
106	Delimiter		1	Character, use the ^ character value	
107-136	Provider Business Mailing Address (Second line address)		30	Character	O
137	Delimiter		1	Character, use the ^ character value	
138-167	Provider Business Mailing Address (City,)		30	Character	R
168	Delimiter		1	Character, use the ^ character value	
169-170	Provider Business Mailing Address (State)	USPS state code abbreviation	2	Character	R
171	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
172-181	Provider Business Mailing Address (9-Digit Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
182	Delimiter		1	Character, use the ^ character value	
183-192	Provider Business Mailing Address (Country Code if outside U.S.)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
193	Delimiter		1	Character, use the ^ character value	
194-203	Provider Business Mailing Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
204	Delimiter		1	Character, use the ^ character value	
205-214	Provider Business Mailing Address (Fax Number)	Do not enter dashes or parentheses.	10	Numeric	O
215	Delimiter		1	Character, use the ^ character value	
216-245	Provider Business Location Address (First line address)	No P.O. Box here, please use a physical address.	30	Character	R
246	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
247-276	Provider Business Location Address (Second line address)		30	Character	O
277	Delimiter		1	Character, use the ^ character value	
278-307	Provider Business Location Address (City,)		30	Character	R
308	Delimiter		1	Character, use the ^ character value	
309-310	Provider Business Location Address (State)		2	USPS state code abbreviation	R
311	Delimiter		1	Character, use the ^ character value	
312-321	Provider Business Location Address (Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
322	Delimiter		1	Character, use the ^ character value	
323-332	Provider Business Location Address (Country Code if outside U.S)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
333	Delimiter		1	Character, use the ^ character value	
334-343	Provider Business	Do not enter dashes or	10	Numeric	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Location Address (Telephone Number)	parentheses.			
344	Delimiter		1	Character, use the ^ character value	
345-354	Provider Business Location Address (Fax Number)	Do not enter dashes or parentheses.	10	Numeric	O
355	Delimiter		1	Character, use the ^ character value	
356-365	Healthcare Provider Taxonomy Code 1		10	Character	R Note: if a single NPI is used for multiple entities then we require at least 1 taxonomy per NPI. For example, if a single NPI is used for an acute care hospital as well as a DPPU in the hospital, then we need taxonomy for both units… each sent in a separte record.
366	Delimiter		1	Character, use the ^ character value	
367-376	Healthcare Provider Taxonomy Code 2	Use if necessary; otherwise leave blank.	10	Character	O
377	Delimiter		1	Character, use the ^ character	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				value	
378-387	Healthcare Provider Taxonomy Code 3	Use if necessary; otherwise leave blank.	10	Character	O
388	Delimiter		1	Character, use the ^ character value	
389-395	Other Provider Identifier	If available, enter the provider's Louisiana Medicaid Provider ID	7	Numeric, left-fill with zeroes.	R, if provider is already enrolled with Medicaid; otherwise, optional.
396	Delimiter		1	Character, use the ^ character value	
397-400	Other Provider Identifier Type Code	Provider Type and Provider Specialty	4	1st 2 characters are provider type; last 2 characters (3-4) are provider specialty. See DBPM Companion Guide for list of applicable provider types and specialties.	R
401	Delimiter		1	Character, use the ^ character value	
402-409	Provider Enumeration Date	NPPES enumeration date.	8	Numeric, format YYYYMMDD	R
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update	NPPES last	8	Numeric, format	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Date	update date; leave all zeros if not available.		YYYYMMDD	
419	Delimiter		1	Character, use the ^ character value	
420-439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate.	20	Left justify, right-fill with spaces.	O
440	Delimiter		1	Character, use the ^ character value	
441-448	NPI Deactivation Date	NPPES deactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
449	Delimiter		1	Character, use the ^ character value	
450-457	NPI Reactivation Date	NPPES reactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
458	Delimiter		1	Character, use the ^ character value	
459	Provider Gender Code	**M**=Male, **F**=Female, **N**=Not applicable	1	Character .	R
460	Delimiter		1	Character, use the ^ character value	
461-480	Provider License Number		20	Character, left-justified, right-fill with spaces.	R
481	Delimiter		1	Character, use	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				the ^ character value	
482-483	Provider License Number State Code	2-character USPS state code value	2	Character	R
484	Delimiter		1	Character, use the ^ character value	
485-534	Authorized Official Contact Information (First Name, Middle Name, Last Name)		50	Character, left-justified, right-fill with spaces.	R
535	Delimiter		1	Character, use the ^ character value	
536-565	Authorized Official Contact Information (Title or Position)		30	Character, left-justified, right-fill with spaces.	O
566	Delimiter		1	Character, use the ^ character value	
567-576	Authorized Official Contact Information (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
577	Delimiter		1	Character, use the ^ character value	
578	Panel Open Indicator	**Y**=Yes, panel is open. **N**=No, panel is not open.	1	Character	R for PCPs; otherwise optional.
579	Delimiter		1	Character, use	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				the ^ character value	
580	Language Indicator 1 (this is the primary language indicator)	1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
581	Delimiter		1	Character, use the ^ character value	
582	Language Indicator 2 (this is a secondary language indicator)	0=no other language supported 1= Accepts English-speaking patients 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
583	Delimiter		1	Character, use the ^ character	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				value	
584	Language Indicator 3 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
585	Delimiter		1	Character, use the ^ character value	
586	Language Indicator 4 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
587	Delimiter		1	Character, use the ^ character value	
588	Language Indicator 5 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
589	Delimiter		1	Character, use the ^ character value	
590	Age Restriction Indicator	**0**=no age restrictions **1**=adult only **2**=pediatric only	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
591	Delimiter		1	Character, use the ^ character value	
592-596	PCP Linkage Maximum	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of patients that can	R for PCPs; otherwise optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	
597	Delimiter		1	Character, use the ^ character value	
598-602	PCP Linkages with DBP	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of DBP enrollees that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
603	Delimiter		1	Character, use the ^ character value	
604-608	PCP Linkages with Others	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of enrollees in other plans (not DBP) that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
609	Delimiter		1	Character, use the ^ character	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				value	
610	DBP Enrollment Indicator	**N**=New enrollment **C**=Change to existing enrollment **D**=Disenrollment	1	Use this field to identify new providers, changes to existing providers, and disenrolled providers	R
611	Delimiter		1	Character, use the ^ character value	
612-619	DBP Enrollment Indicator Effective Date	Effective date of Enrollment Indicator above.	8	Numeric, format YYYYMMDD	R
620	Delimiter		1	Character, use the ^ character value	
621	Family Only Indicator	**0**=no restrictions **1**=family members only	1		R for PCPs; otherwise optional.
622	Delimiter		1	Character, use the ^ character value	
623-624	Provider Sub-Specialty 1	Value set is determined by DHH and is available in DBPM Companion Guide	2		~~O~~ R for PCPs; otherwise optional.
625	Delimiter		1	Character, use the ^ character value	
626-627	Provider Sub-Specialty 2	If necessary, Value set is determined by DHH and is available in DBPM	2		O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		Companion Guide			
628	Delimiter		1	Character, use the ^ character value	
629-630	Provider Sub-Specialty 3	If necessary, Value set is determined by DHH and is available in DBPM Companion Guide	2		O
631	Delimiter		1	Character, use the ^ character value	
632-661	DBP Contract Name or Number	This should represent the contract name/number that is established between the DBP and the Provider	30	Character	R
662	Delimiter		1	Character, use the ^ character value	
663-670	DBP Contract Begin Date	Date that the contract between the DBP and the provider started	8	Numeric date value in the form YYYYMMDD	R
671	Delimiter		1	Character, use the ^ character value	
672-679	DBP Contract Term Date	Date that the contract between the DBP and the provider was terminated.	8	Numeric date value in the form YYYYMMDD	O
680	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
681-682	Provider Parish served – 1st or primary	Parish code value that represents the primary parish that the provider serves	2	2-digit parish code value. See the DBPM Companion Guide.	R
683	Delimiter		1	Character, use the ^ character value	
684-685	Provider Parish served – 2nd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
686	Delimiter		1	Character, use the ^ character value	
687-688	Provider Parish served – 3rd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
689	Delimiter		1	Character, use the ^ character value	
690-691	Provider Parish served – 4th	Parish code value that represents a secondary or other parish that the provider serves.	2	2-digit parish code value. See the DBPM Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		Use only if necessary; otherwise enter 00.			
692	Delimiter		1	Character, use the ^ character value	
693-694	Provider Parish served – 5th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
695	Delimiter		1	Character, use the ^ character value	
696-697	Provider Parish served – 6th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
698	Delimiter		1	Character, use the ^ character value	
699-700	Provider Parish served – 7th	Parish code value that represents a secondary or other parish that the provider serves. Use only if	2	2-digit parish code value. See the DBPM Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		necessary; otherwise enter 00.			
701	Delimiter		1	Character, use the ^ character value	
702-703	Provider Parish served – 8th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
704	Delimiter		1	Character, use the ^ character value	
705-706	Provider Parish served – 9th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
707	Delimiter		1	Character, use the ^ character value	
708-709	Provider Parish served – 10th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary;	2	2-digit parish code value. See the DBPM Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		otherwise enter 00.			
710	Delimiter		1	Character, use the ^ character value	
711-712	Provider Parish served – 11th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
713	Delimiter		1	Character, use the ^ character value	
714-715	Provider Parish served – 12th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
716	Delimiter		1	Character, use the ^ character value	
717-718	Provider Parish served – 13th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter	2	2-digit parish code value. See the DBPM Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		00.			
719	Delimiter		1	Character, use the ^ character value	
720-721	Provider Parish served – 14th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
722	Delimiter		1	Character, use the ^ character value	
723-724	Provider Parish served – 15th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	
726-749	Spaces	End of record filler	24	Enter all spaces	
750	End of record delimiter		1	Character, use the ^ character value	

Provider Registry Edit Report (sample)

Report: MW-W-09 *RUN DATE: 20140606* *1*

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Statewide Management Organization
Report MW-W-09: Weekly Provider Registry Edit/Update Report

19:30 Friday, June 6, 2014

SMO_ID=0136558

RECORD TYPE	PROV ID	NPI	NAME	ASSIGNED TAXONOMY	MEDICAID ID	ACC REJ	ERR1	ERR2	ERR3	ERR4	ERR5	ERR6	ERR7	ERR8	ERR9	ERR10
C	0000000	1235219999	TEST TX TRMNT NTWRK MAIN	283Q00000X	7130001	A	025	035	000	000	000	000	000	000	000	000

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Statewide Management Organization
Report MW-W-09: Weekly Provider Registry Edit/Update Report

19:30 Friday, June 6, 2014

SMO_ID=0136558

Error Codes (A=Accepted, R=Rejected):
000=(A) No errors found
001=(R) Missing/Invalid NPI (not 10 digits)
002=(R) Missing/Invalid Entity Type (must be 1 or 2)
003=(R) Provider record must include taxonomy
004=(R) Missing required information (name, address, contact name, etc.)
005=(R) Missing/Invalid provider type or specialty
006=(R) Invalid provider sub-specialty (if one is submitted and it is not a valid value)
007=(R) Missing/Invalid enrollment indicator (must be N, C, or D)
008=(R) Missing/Invalid enrollment effective date
009=(R) Invalid panel open indicator value (must be Y, N)
010=(R) Invalid Language indicator value (must be 0,1,2,3,4,5. 1st indicator cannot be 0)
011=(R) Invalid Age Restriction indicator value (must be 0,1,2)
012=(R) Invalid PCP Linkage Maximum value (must be numeric or zeros)
013=(R) Invalid PCP Linkage SMO value (must be numeric or zeros)
014=(R) Invalid PCP Linkage Other value (must be numeric or zeros)
015=(R) Invalid Family-Only indicator value (must be 0,1)
016=(R) Missing SMO Contract Name or Number (found only spaces)
017=(R) Missing/Invalid SMO Contract begin date
018=(R) Missing/Invalid SMO Contract termination date
019=(R) Missing provider parish (at least 1 must be submitted)
020=(R) Invalid provider parish value (for a submitted value)
021=(R) Duplicate NPI records found. Only first one in the file is accepted
022=(R) Medicaid Provider ID (Other Provider Identifier) is not found on MMIS Provider File
023=(R) Missing/Invalid NPPES Enum Date
024=(R) Missing/Invalid Provider License Data
025=(A) NPI not found on LMMIS Provider Enrollment File
026=(R) SMO provider not found on LMMIS Provider Enrollment File
027=(R) Unable to assign a Medicaid provider... too many collisions
028=(R) Enrollment Ind=N (new), but provider already exists on registry
029=(R) Enrollment Ind=C or D, but provider does not exist on registry
030=(R) Invalid taxonomy format (Special characters not allowed)
031=(R) Missing Replacement NPI for an atypical provider
035=(A) Non-Par Contractor

Provider Registry Edit file layout

Columns	Field Name	Format	Size	Comments
1-7	Plan ID number	Numeric	7 digits	This is the plan ID.
8	Delimiter	Character	1	Value is ^ character.
9	Enroll Code	Character	1	Submitted by plan: N=New C=Change D=Disenroll
10	Delimiter	Character	1	Value is ^ character.
11-17	Provider ID	Numeric	7 digits	This is the provider's Medicaid ID number
18	Delimiter	Character	1	Value is ^ character.
19-28	Provider NPI	Character	10	
29	Delimiter	Character	1	Value is ^ character.
30-59	Provider Name	Character	30	
60	Delimiter	Character	1	Value is ^ character.
61-70	Provider Taxonomy	Character	10	
71	Delimiter	Character	1	Value is ^ character.
72-78	Provider ID	Numeric	7 digits	
79	Delimiter	Character	1	Value is ^ character.
80	Molina Accept/Reject Indicator	Character	1	A=Accepted R=Rejected
81	Delimiter	Character	1	Value is ^ character.
82-84	Edit Code 1	Character	3	
85	Delimiter	Character	1	Value is ^ character.
86-88	Edit Code 2	Character	3	
89	Delimiter	Character	1	Value is ^ character.
90-92	Edit Code 3	Character	3	
93	Delimiter	Character	1	Value is ^ character.
94-96	Edit Code 4	Character	3	
97	Delimiter	Character	1	Value is ^ character.
98-100	Edit Code 5	Character	3	
101	Delimiter	Character	1	Value is ^ character.
102-104	Edit Code 6	Character	3	
105	Delimiter	Character	1	Value is ^ character.
106-108	Edit Code 7	Character	3	
109	Delimiter	Character	1	Value is ^ character.

110-112	Edit Code 8	Character	3	
113	Delimiter	Character	1	Value is ^ character.
114-116	Edit Code 9	Character	3	
117	Delimiter	Character	1	Value is ^ character.
118-120	Edit Code 10	Character	3	
121	Delimiter	Character	1	Value is ^ character.

Appendix H

Test Plan

This appendix provides a step-by-step account of the FI's plan for testing the ASC X12N 837 COB and 835 electronic transaction sets for use in submitting encounter data for storage in the MMIS claims history file. The plan consists of three (3) tiers of testing, which are outlined in detail below.

Testing Tier I

The first step in submitter testing is enrollment performed via Molina Electronic Data Interchange (EDI) Services, Inc. Each Health Plan must enroll with EDI to receive a Trading Partner ID in order to submit electronic encounter data. The Health Plan will already have an ID, but are only permitted to receive electronic transactions; e.g. 834, 820, not to submit them. In this step, permission is granted for the Health Plan to be able to both transmit and receive.

The second step performed concurrently with the enrollment, is EDIFECS testing. A partnership exists between EDIFECS and Molina Electronic Data Interchange (EDI) Services, Inc. to assist in compliance testing and tracking submitter test files prior to submission through the Molina Electronic Data Interchange (EDI). There are certain errors that will occur while testing with EDIFECS that shall not be considered when determining whether the Health Plan has passed or failed the EDIFECS portion of testing.

EDI must certify the Health Plan prior to the MMIS receipt of encounters via EDI. The objective is to ensure that the submitter can generate a valid X12 transaction, submit the transaction to the Molina Electronic Data Interchange (EDI), and that the transaction can be processed successfully with the resultant IRL, 999 Acceptance, or return transaction. X12 837 transactions (837D, 837I and 837P) must be in the 5010 format. This phase of testing was designed to do the following:

- test connectivity with the Clearinghouse;
- validate Trading Partner IDs;
- validate the ability of the submitter to create and transmit X12 transactions with all required loops, segments, and data elements;
- validate the test submission with 999 Acceptance transactions; and
- generate IRL or paired transaction.

Once EDIFECS testing is complete, the Health Plan is certified that the X12 transaction is properly formatted to submit to the MMIS. The encounter claims data from the Health Plan is identified by the value 'RP' being present in X12 field TX-TYPE-CODE field. The Health Plan must ensure that their Medicaid IDs are in loop 2330B segment NM1 in 'Other Payer Primary Identification Number'. If line item DBP paid amount is submitted, they also need to populate the 'Other Payer Primary Identifier' in loop 2430 segment SVD with their Medicaid provider number. These fields are used in the MMIS pre-processors to indicate that the amount in the accompanying prior paid field is the Health Plan's paid amount and not TPL or any other COB amount. For more details, please refer to the Molina Electronic Data Interchange (EDI) Services, Inc. *Submitter Testing Report* for the DHH.

Testing Tier II

Once the Health Plan has successfully passed more than 50% of their encounter data claims through the pre-processors, Molina will process the encounters through the MMIS Adjudication cycle and the Payment cycle. The Payment cycle will create an 835 transaction to be retrieved by the Health Plan via IDEX. The Health Plan is required to examine the returned 835s and compare them to the encounter data claims (837s) they submitted to ensure all claims that were submitted are accounted for in the data collection. Molina will send the new edit code reports to the Health Plan and DHH for evaluation as well as a MMIS edit code explanation document which details the conditions under which each edit code will post to an encounter data claim in order to assist them with their research. Molina is available to answer any questions that the Health Plan may have concerning the edit codes.

Testing Tier III

Once satisfactory test results are documented, Molina will move the Health Plan into production. Molina anticipates receiving files from the Health Plan in production mode at least once monthly.

Appendix I

Websites

The following websites are provided as references for useful information not only for Health Plan entities, but also for consumers, health care providers, health care organizations, and other impacted entities.

Website Address	Website Contents
http://aspe.hhs.gov/admnsimp/	This links to the **Department of Health and Human Services website regarding the Administrative Simplification provisions of HIPAA**. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.
http://www.cms.gov	This is the **CMS home page**.
http://www.wedi.org/snip/	This is the **Workgroup for Electronic Data Interchange website**. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions.

Website Address	Website Contents
http://www.wpc-edi.com/hipaa/HIPAA_40.asp	This links to the **Washington Publishing Company website**. This site contains all the implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards being proposed under HIPAA of 1996. They may be downloaded for free.
http://www.ansi.org	This is the **American National Standards Institute website** that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process.
http://www.x12.org	This is the **Data Interchange Standards Association website**. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.nubc.org	This is the **National Uniform Billing Committee website**. This site contains NUBC meeting minutes, activities, materials, and deliberations.
http://www.nucc.org	This is the **National Uniform**

Website Address	Website Contents
	Claims Committee website. This site includes a data set identified by the NUCC for submitting non-institutional claims, encounters, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations.
http://HL7.org	This site contains information on Logical Observation Identifier Names and Codes (LOINC) - **Health Level Seven (HL7)**. HL7 is being considered for requests for attachment information.
http://www.cms.hhs.gov/home/medicare.asp	This is the **Medicare EDI website**. At this site, you will find information regarding Medicare EDI, advantages to using Medicare EDI, Medicare EDI formats and instructions, news and events, frequently asked questions about Medicare EDI, and information regarding Medicare paper forms and instructions.
http://www.cms.hhs.gov/medicaid/hipaa/adminsim/hipaapls.asp	This is a **monthly newsletter published by CMS's Data and System Group within the Center for Medicaid and State Operations**. It is a very good source of information for HIPAA developments. If you cannot access the website with the direct address, use http://www.cms.gov. Click on Medicaid and search using the keywords "HIPAA Plus".

Appendix J

Common Data Element Values

Parish Code	Recipient Parish Description
01	Acadia
02	Allen
03	Ascension
04	Assumption
05	Avoyelles
06	Beauregard
07	Bienville
08	Bossier
09	Caddo
10	Calcasieu
11	Caldwell
12	Cameron
13	Catahoula
14	Claiborne
15	Concordia
16	Desoto
17	East Baton Rouge
18	East Carroll
19	East Feliciana
20	Evangeline
21	Franklin
22	Grant
23	Iberia
24	Iberville
25	Jackson
26	Jefferson
27	Jefferson Davis
28	Lafayette
29	Lafourche
30	LaSalle
31	Lincoln
32	Livingston
33	Madison
34	Morehouse
35	Natchitoches

36	Orleans
37	Ouachita
38	Plaquemines
39	Pointe Coupee
40	Rapides
41	Red River
42	Richland
43	Sabine
44	St Bernard
45	St Charles
46	St Helena
47	St James
48	St John
49	St Landry
50	St Martin
51	St Mary
52	St Tammany
53	Tangipahoa
54	Tensas
55	Terrebonne
56	Union
57	Vermilion
58	Vermilion
59	Washington
60	Webster
61	West Baton Rouge
62	West Carroll
63	West Feliciana
64	Winn
65	East Jefferson

The following common data element values are provided as references for useful information for Managed Care entities.

Type of Service (TOS)

TOS Code	Description
00	Not applicable
01	Anesthesia
02	Assistant Surgeon
03	Full-Service Physician, Labs, NEMT, Lab 60%, PACE capitation
04	Adult Dental, 62% Lab
05	Professional Component
06	Pharmacy, Crossover Immuno Drugs
07	RHC, FQHC, CommunityCARE Enhanced, 0 – 15 y/o Enhanced
08	DEFRA, Lab 62%, Ambulatory Surgery, Outpatient Hospital Rehab
09	DME, Emergency Ambulance Services (EMT), Prenatal Care Clinic Services, EPSDT Case Management, VACP, Nurse Home Visits, Infants & Toddlers, HIV, High-Risk Pregnant Women, Vision Eyeglass Program, Personal Care Services(EPSDT), Rehabilitation Centers
10	Family Planning Clinics
11	Mental Health
12	School Boards and Early Intervention Centers
13	Office of Public Health (OPH)
14	Psychological and Behavioral Services (PBS)
15	Outpatient Ambulatory Surgical Services
16	Personal Attendant Services (PAS) -- Ticket to Work Program

17	Home Health
18	Expanded Dental Services for Pregnant Women (EDSPW)
19	Personal Care Services (LTC)
20	Enhanced Outpatient Rehab Services
21	EPSDT, EPSDT Dental
22	Childnet (Early Steps)
23	Waiver - Children's Choice
24	Waiver - ADHC
25	Waiver - EDA
26	Waiver - PCA
27	Special Purpose Facility
28	Center Based Special Purpose Facility
29	American Indian
30	Acute Care Outpatient Services
31	Family Planning Waiver
32	Supports Waiver
33	New Opportunity Waiver (NOW)
34	DME Special Rates
35	Residential Options Waiver (ROW)
36	Community Mental Health Center
37	Small Rural Hospital Outpatient
38	Adult Residential Care (ARC)
39	State Hospital Outpatient Services
40	Sole Community Hospital
41	Psychiatric Residential Treatment Facility

42	Mental Health Rehabilitation
43	LaPOP, Louisiana Personal Options Program
44	Pediatric Day Health Care Facility (PDHC)
45	Coordinated Care Network - Pre-paid (CCN-P)
46	Coordinated Care Network - Shared Services (CCN-S)

Category of Service (COS)

State COS	Description
00	Inpatient Service in TB Hospital
01	Inpatient Service in General Hospital
02	Inpatient Service in Mental Hospital
03	SNF Service
04	ICF-DD
05	ICF-I Service
06	ICF-II Service
07	Physician Services
08	Outpatient Hospital Services
09	Clinic - Hemodialysis
10	Clinic - Alcohol & Substance Abuse
11	Clinic - Mental Health
12	Clinic - Ambulatory Surgical
13	Rehab Services
14	Adult Day Care
15	Independent Lab
16	Chiropractic Services
17	Home Health
18	Prescribed Drugs and Immunizations by Pharmacists
19	Habilitation

20	DME (Appliances)
21	Rural Health Clinics
22	Family Planning Service
23	Non-Emergency Medical Transportation
24	Medical Transportation
25	Adult Dental Services
26	EPSDT - Screening Services
27	EPSDT - Dental
28	EPSDT - Other
29	Homemaker Services
30	Other Medical Services
31	Default
32	Administrative Error State Funds Only
33	Recovery Unidentified Services
34	EPSDT Health Services Non-School Board
35	Medical TPL
36	Title XIX Health Insurance Payment
37	Case Management
38	FQHC
39	PCA
40	Personal Health Care Clinic Services
41	HMO Over 65
42	Rehab for Chronically Mentally Ill
43	Childrens' Choice Waiver

44	EPSDT - Personal Care Services
45	Dental Services for Pregnant Women
46	EPSDT Health Services
47	VD Clinic
48	TB Clinic
49	Title XIX Part-A Premium
50	Psychology
51	Audiology
52	Physical Therapy
53	Multi-Specialty Clinic Services
54	Certified Registered Nurse (CRNA)
55	Private Duty Nurse
56	Occupational Therapy
57	CM - HIV
58	CM - CMI
59	CM - PW
60	Rehab - ICF/DD
61	CM - DD
62	DD Waiver
63	CM - Infants & Toddlers
64	Home Care Elderly Waiver
65	Head Injury Maintenance Waiver
66	Hospice / NF
67	Social Worker Services

68	Contractors / CM
69	Nurse Home Visits - First Time Mothers Program
70	NOW Waiver
71	LTC - Personal Care Services
72	PAS - Personal Care Services
73	Early Steps
74	Behavior Management Services
75	PACE
76	American Indian/Native Alaskans
77	Family Planning Waiver
78	Support Waiver
79	Community Mental Health Center
80	Residential Options Waiver (ROW)
81	Coordinated Care Network
91	Coded for internal purposes only
99	LTC Administrative Cost

Provider Specialty, Sub-Specialty

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
00	All Specialties	1
01	General Practice	1
02	General Surgery	1
03	Allergy	1
04	Otology, Laryngology, Rhinology	1
05	Anesthesiology	1
06	Cardiovascular Disease	1
07	Dermatology	1
08	Family Practice	1
09	Gynecology (DO only)	1
10	Gastroenterology	1
11	Not in Use	n/a
12	Manipulative Therapy (DO only)	1
13	Neurology	1
14	Neurological Surgery	1
15	Obstetrics (DO only)	1
16	OB/GYN	1
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	1
18	Ophthalmology	1
19	Orthodontist	1

20	Orthopedic Surgery	1
21	Pathologic Anatomy; Clinical Pathology (DO only)	1
22	Pathology	1
23	Peripheral Vascular Disease or Surgery (DO only)	1
24	Plastic Surgery	1
25	Physical Medicine Rehabilitation	1
26	Psychiatry	1
27	Psychiatry; Neurology (DO only)	1
28	Proctology	1
29	Pulmonary Diseases	1
30	Radiology	1
31	Roentgenology, Radiology (DO only)	1
32	Radiation Therapy (DO only)	1
33	Thoracic Surgery	1
34	Urology	1
35	Chiropractor	1
36	Pre-Vocational Habilitation	1
37	Pediatrics	1
38	Geriatrics	1
39	Nephrology	1
40	Hand Surgery	1
41	Internal Medicine	1
42	Federally Qualified Health Centers	1

43	Not in Use	n/a
44	Public Health	1
45	NEMT - Non-profit	1
46	NEMT - Profit	1
47	NEMT - F+F	1
48	Podiatry - Surgical Chiropody	1
49	Miscellaneous (Admin. Medicine)	1
50	Day Habilitation	1
51	Med Supply / Certified Orthotist	1
52	Med Supply / Certified Prosthetist	1
53	Med Supply / Certified Prosthetist Orthotist	1
54	Med Supply / Not Included in 51, 52, 53	1
55	Indiv Certified Orthotist	1
56	Indiv Certified Protherist	1
57	Indiv Certified Protherist - Orthotist	1
58	Indiv Not Included in 55, 56, 57	1
59	Ambulance Service Supplier, Private	1
60	Public Health or Welfare Agencies & Clinics	1
61	Voluntary Health or Charitable Agencies	1
62	Psychologist Crossovers only	1
63	Portable X-Ray Supplier (Billing Independently)	1
64	Audiologist (Billing Independently)	1
65	Indiv Physical Therapist	1
66	Dentist, DDS, DMS	1

67	Oral Surgeon - Dental	1
68	Pedodontist	1
69	Independent Laboratory (Billing Independently)	1
70	Clinic or Other Group Practice	1
71	Speech Therapy	1
72	Diagnostic Laboratory	1
73	Social Worker Enrollment	1
74	Occupational Therapy	1
75	Other Medical Care	1
76	Adult Day Care	1
77	Habilitation	1
78	Mental Health Rehab	1
79	Nurse Practitioner	1
80	Environmental Modifications	1
81	Case Management	1
82	Personal Care Attendant	1
83	Respite Care	1
84	Substitute Family Care	1
85	Extended Care Hospital	1
86	Hospitals and Nursing Homes	1
87	All Other	1
88	Optician / Optometrist	1
89	Supervised Independent Living	1
90	Personal Emergency Response Sys (Waiver)	1

91	Assistive Devices	1
92	Prescribing Only Providers	1
93	Hospice Service for Dual Elig.	1
94	Rural Health Clinic	1
95	Psychologist (PBS Program Only)	1
96	Psychologist (PBS Program and X-Overs)	1
97	Family Planning Clinic	1
98	Supported Employment	1
99	Provider Pending Enrollment	1
1A	Adolescent Medicine	2
1B	Diagnostic Lab Immunology	2
1C	Neonatal Perinatal Medicine	2
1D	Pediatric Cardiology	2
1E	Pediatric Critical Care Medicine	2
1F	Pediatric Emergency Medicine	2
1G	Pediatric Endocrinology	2
1H	Pediatric Gastroenterology	2
1I	Pediatric Hematology - Oncology	2
1J	Pediatric Infectious Disease	2
1K	Pediatric Nephrology	2
1L	Pediatric Pulmonology	2
1M	Pediatric Rheumatology	2
1N	Pediatric Sports Medicine	2
1P	Pediatric Surgery	2

1S	BRG - Med School	2
1T	Emergency Medicine	1
1Z	Pediatric Day Health Care	1
2A	Cardiac Electrophysiology	2
2B	Cardiovascular Disease	2
2C	Critical Care Medicine	2
2D	Diagnostic Laboratory Immunology	2
2E	Endocrinology & Metabolism	2
2F	Gastroenterology	2
2G	Geriatric Medicine	2
2H	Hematology	2
2I	Infectious Disease	2
2J	Medical Oncology	2
2K	Nephrology	2
2L	Pulmonary Disease	2
2M	Rheumatology	2
2N	Surgery - Critical Care	2
2P	Surgery - General Vascular	2
2R	Physician Assistant	1
2S	LSU Medical Center New Orleans	2
2T	American Indian / Native Alaskan	2
2Y	OPH Genetic Disease Program	1
3A	Critical Care Medicine	2
3B	Gynecologic oncology	2

3C	Maternal & Fetal Medicine	2
3S	LSU Medical Center Shreveport	2
4A	Developmental Disability	1
4B	NOW RN	1
4C	NOW LPN	1
4D	NOW Psychologist	1
4E	NOW Social Worker	1
4R	Registered Dietician	1
4S	Ochsner Med School	2
4X	Waiver-Only Transportation	1
4W	Waiver Services	1
5A	PCS-LTC	1
5B	PCS-EPSDT	1
5C	PAS	1
5D	PCS-LTC, PCS-EPSDT	1
5E	PCS-LTC, PAS	1
5F	PCS-EPSDT, PAS	1
5G	OCS-LTC, PCS-EPSDT, PAS	1
5H	Community Mental Health Center	
5M	Multi-Systemic Therapy	
5P	PACE	1
5Q	CCN-P (Coordinated Care Network, Prepaid)	1
5R	CCN-S (Coordinated Care Network, Shared Savings)	
5S	Tulane Med School	2

6A	Psychologist -Clinical	1
6B	Psychologist-Counseling	1
6C	Psychologist - School	1
6D	Psychologist - Developmental	1
6E	Psychologist - Non-Declared	1
6F	Psychologist - All Other	1
6H	LaPOP	1
6N	Endodontist	1
6P	Periodontist	1
6S	E Jefferson Fam Practice Ctr - Residency Program	2
7A	SBHC - NP - Part Time - less than 20 hrs week	1
7B	SBHC - NP - Full Time - 20 or more hrs week	1
7C	SBHC - MD - Part Time - less than 20 hrs week	1
7D	SBHC - MD - Full Time - 20 or more hrs week	1
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	1
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	1
7M	Retail Convenience Clinics	2
7N	Urgent Care Clinics	2
7S	Leonard J Chabert Medical Center - Houma	2
8A	EDA & DD services	2
8B	EDA services	2
8C	DD services	2
9B	Psychiatric Residential Treatment Facility	1

9D	Residential Care	1
9E	Children's Choice Waiver	1
9L	RHC/FQHC OPH Certified SBHC	1
9Q	PT 21 - EDI Independent Billing Company	2
9U	Medicare Advantage Plans	1
9V	OCDD - Point of Entry	1
9W	OASS - Point of Entry	1
9X	OAD	1
9Z	Other Contract with a State Agency	1

Pricing Action Code (PAC)

PAC	Description
MEDICAL	
250	Price at Level III - Anesthesia
260	Price as for Anesthesia
810	Price manually, individual consideration (IC)
820	Deny
830	Price at Level I (U&C File)
850	Price at Level III - Louisiana BHSF set price on Procedure/Formulary File
860	Price at Level I and Level II (U&C File and Prevailing Fee File)
880	Maximum amount - Pend if billed charge is greater than Procedure/Formulary price
8F0	Maximum amount - Pay at billed amount
DENTAL	
610	Manage Price
620	Deny
630	Price at Level I (U&C File)
650	Price at Level III - Louisiana BHSF set price on Procedure/Formulary File
660	Price at Level I and II (U&C File and Prevailing Fee File)
680	Maximum Amount - Pend if billed charge is greater than Procedure/Formulary File
6F0	Maximum Amount - Pay at billed amount

Appendix K

TPL Requirements

Third Party Liability (TPL)

TPL Requirement Format

The DBPM shall provide DHH Third Party Liability information in a format and medium described by DHH and shall cooperate in any manner necessary, as requested by DHH, with DHH and/or a cost recovery vendor of DHH.

On a weekly basis, the DBPM is required to submit the FI (Molina) the File layout along with the instructions.

Batch Electronic File Layout for TPL Information

Subject to Change

PART 1: PLAN FILE SUBMISSIONS

File submissions should occur once per week on or before Thursday COB (5:00 p.m. CT) unless it is a holiday and then you may submit the file on the previous applicable work day. If you choose to do so because it is applicable to your processing environment, you may submit a file on Thursday if it is a holiday.

You may submit only one file per week, so your file should contain all records that you expect to submit during that week.

If you don't have records to submit in a given week, then you should still submit a file, but it should be empty.

File submission instructions, with respect to using Molina's FTP site, will be distributed in the near future.

Plan File submission naming convention: **TPL-BATCH-NNNNNNN-YYYYMMDD.txt**
Where NNNNNNN is your Plan ID (0136558=MCNA), and YYYYMMDD is the date of submission.

The submission file has a fixed-length record format. Each record is 700 characters in length, and uses the following record layout. As noted, specific fields are required (R) and other fields are optional (O). If a field is optional, then a value of space(s) is acceptable, unless otherwise noted. If you enter a value that is not spaces, the value will be edited appropriately. The file does not use delimiters and is formatted as an ASCII text file.

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
1	1-8	TPL_CREATE_DATE	char(8)	R	YYYYMMDD, e.g. 20121017 Date that the TPL record was created.
2	9-14	TPL_CREATE_TIME	char(6)	R	HHMMSS in military time, e.g. 235959 Time that the TPL record was created.
3	15	TPL_RECORD_SOURCE_CD	char(1)	R	Value: **1=general TPL update.**
4	16-27	TPL_PRI_INDIV_NAME_LAST	char(12)	R	Left Justify
5	28-34	TPL_PRI_INDIV_NAME_FIRST	char(7)	R	Left Justify
6	35	TPL_PRI_INDIV_NAME_MI	char(1)	R	Use a space if not available
7	36-48	TPL_PRI_MED_ID_NO	char(13)	R	Medicaid recipient ID
8	49-57	TPL_PRI_INSURED_SSN	char(9)	R	Enter a valid SSN
9	58-59	TPL_INITIATOR_CODE	char(2)	R	Value: **19=MCNA**

10	60-71	TPL_CASE_NAME_LAST	char(12)	O	Left justify
11	72-78	TPL_CASE_NAME_FIRST	char(7)	O	Left justify
12	79	TPL_CASE_NAME_MI	char(1)	O	Use a space if not available
13	80-92	TPL_CASE_ID	char(13)	O	Leave spaces if not used
14	93-96	TPL_CASELOAD_NO	char(4)	O	Leave spaces if not used
15	97-108	TPL_POLICY_HOLDER_NAME_LAST	char(12)	R	Left justify
16	109-115	TPL_POLICY_HOLDER_NAME_FIRST	char(7)	R	Left justify
17	116	TPL_POLICY_HOLDER_NAME_MI	char(1)	R	Use a space if not available
18	117-141	TPL_POLICY_HOLDER_STREET	char(25)	R	Left justify
19	142-161	TPL_POLICY_HOLDER_CITY	char(20)	R	Left Justify
20	162-163	TPL_POLICY_HOLDER_STATE	char(2)	R	USPS abbreviation
21	164-172	TPL_POLICY_HOLDER_ZIP	char(9)	R	Left Justify
22	173-181	TPL_POLICY_HOLDER_SSN	char(9)	O	Use all zeros if not available
23	182-234	TPL_EMPLOYER_GRP_MAINT_COVER	char(53)	O	Left Justify
24	235-259	TPL_EMPLOYER_CLAIM_FIL_STREET	char(25)	O	Left Justify
25	260-279	TPL_EMPLOYER_CLAIM_FIL_CITY	char(20)	O	Left Justify
26	280-281	TPL_EMPLOYER_CLAIM_FIL_STATE	char(2)	O	Left Justify
27	282-290	TPL_EMPLOYER_CLAIM_FIL_ZIP	char(9)	O	Left Justify
28	291-343	TPL_INSURANCE_NAME	char(53)	R	Left Justify
29	344-349	TPL_INSURANCE_NUMBER	char(6)	R	Use the appropriate Louisiana MMIS Carrier Code
30	350-374	TPL_INSURANCE_CLAIM_FIL_STREET	char(25)	R	Left Justify
31	375-394	TPL_INSURANCE_CLAIM_FIL_CITY	char(20)	R	Left Justify
32	395-396	TPL_INSURANCE_CLAIM_FIL_STATE	char(2)	R	USPS abbreviation
33	397-405	TPL_INSURANCE_CLAIM_FIL_ZIP	char(9)	R	Left Justify
34	406-418	TPL_POL_NBR	char(13)	R	Left Justify
35	419-433	TPL_GROUP_NBR	char(15)	O	Left Justify, leave blank if not used.
36	434-435	TPL_SCOPE_OF_COVERAGE_1	char(2)	R	See Scopes of Coverage in SCG.
37	436-437	TPL_SCOPE_OF_COVERAGE_2	char(2)	O	See Scopes of Coverage in SCG, if provided.
38	438	TPL_SCOPE_OF_COVERAGE_CD_1	char(1)	O	Leave space.
39	439	TPL_SCOPE_OF_COVERAGE_CD_2	char(1)	O	Leave space.
40	440-447	TPL_BEGIN_DATE_YYMMDD	char(8)	R	YYYYMMDD
41	448-455	TPL_END_DATE_YYMMDD	char(8)	R	YYYYMMDD
42	456-480	TPL_AGENT_NAME	char(25)	O	Left Justify
43	481-490	TPL_AGENT_PHONE	char(10)	O	Left Justify
44	491-515	TPL_AGENT_STREET	char(25)	O	Left Justify

45	516-535	TPL_AGENT_CITY	char(20)	O	Left Justify
46	536-537	TPL_AGENT_STATE	char(2)	O	Left Justify
47	538-546	TPL_AGENT_ZIP	char(9)	O	Left Justify
48	547-548	TPL_PARISH	char(2)	O	**Use a parish code value from 01-64 or 77.** See Parish Code table in SCG.
49	549	FILLER	char(1)	O	Leave space.
50	550-562	TPL_PRIV_INSUR_SUBMIT_ID	char(13)	O	Leave spaces.
51	563-567	TPL_PRIV_DOB	char(5)	O	Leave spaces.
52	568-569	TPL_PRIV_CAT	char(2)	O	Leave spaces.
53	570	TPL_PROCESS_TYPE	char(1)	R	Values: **1=new entry,** **3=update existing entry,**
54	571-577	TPL_SEQUENCE_NUMBER	char(7)	R	File record sequence number: The first record in the file should have number 0000001, the second 0000002, etc.
55	578-585	TPL_LAHIPP_BEGIN_DATE	char(8)	O	Leave spaces.
56	586-593	TPL_LAHIPP_END_DATE	char(8)	O	Leave spaces.
57	594-700	TPL_FILLER	char(107)	R	Leave all spaces.

END OF RECORD LAYOUT

PART 2: SUBMISSION EDIT PROCESS

Molina will capture your file, archive it, and send it to HMS, the DHH TPL contractor. HMS will perform limited edits on the file and send them back to Molina for update processing on the LMMIS TPL Resource File. Molina's update process performs extensive edits and produces an error report for HMS, and we will also create an error text file and send it back to you via your FTP server (showing only your submitted records, if they hit an edit). If none of your records hit an edit, we will send back an empty error text file.

The error text file will use the naming convention: **TPL-ERROR-NNNNNNN-YYYYMMDD.txt**
Where NNNNNNN is your Plan ID (0136558=MCNA), and YYYYMMDD is the date from your submission file.

The error text file will have this layout:

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***Notes***
1	1-7	TPL_SEQUENCE_NUMBER	char(7)	File record sequence number from your submission.
2	8-20	TPL_PRI_MED_ID_NO	char(13)	Medicaid recipient ID from your submission.
3	21-29	TPL_PRI_INSURED_SSN	char(9)	SSN from your submission.

4	30-32	ERROR CODE 1	char(3)	3-digit number representing error code (see below).
5	33-35	ERROR CODE 2	char(3)	2nd 3-digit error code, if necessary.
6	36-38	ERROR CODE 3	char(3)	3rd 3-digit error code, if necessary.
7	39-41	ERROR CODE 4	char(3)	4th 3-digit error code, if necessary.
8	42	END-OF-RECORD INDICATOR	char(1)	Value is "#".

ERROR CODES

Error codes are associated with the Field values shown in the submission record layout shown above. So, for example:

003 Invalid value for Field 3 (TPL_RECORD_SOURCE_CD)

004 Invalid value for Field 4 (TPL_PRI_INDIV_NAME_LAST)

009 Invalid value for Field 9 (TPL_INITIATOR_CODE). Your assigned initiator code must correspond to your Plan ID.

029 Invalid value for Field 29 (TPL_INSURANCE_NUMBER). Value is not found on LMMIS Carrier Code file. If TPL_PROCESS_TYPE=3 then value was not found on Recipient's TPL record.

034 Invalid value for Field 34 (TPL_POL_NBR). Value is blank or all 0s or all 9s.

035 Invalid value for Field 35 (TPL_GROUP_NBR). Value is blank or all 0s or all 9s.

040 Invalid value for Field 40 (TPL_BEGIN_DATE_YYMMDD). Must be a valid date value.

041 Invalid value for Field 41 (TPL_END_DATE_YYMMDD). Must be a valid date value and must be >= Field 40.

046 Invalid value for Field 46 (TPL_AGENT_STATE). A non-blank value was submitted and it does not represent a valid USPS state code.

047 Invalid value for Field 47 (TPL_AGENT_ZIP). A non-blank value was submitted and it is not a 5-digit or 9-digit number.

048 Invalid value for Field 48 (TPL_PARISH). A non-blank value was submitted and it is not a valid LMMIS parish code value.

053 Invalid value for Field 53 (TPL_PROCESS_TYPE). Must be 1 or 3. If value is 1, then a record must not exist (on the LMMIS TPL Resource File). If value is 3, then a record must exist.

054 Invalid value for Field 54 (TPL_SEQUENCE_NUMBER). Must be a number and must be unique in the file.

The above examples represent some of the error codes, all of which range from 001 to 056.

Anytime you receive a record in the edit text file, it indicates that the associated record in your submission file failed to update the LMMIS TPL Resource File. If you receive no error record for a submitted record (based on the TPL_SEQUENCE_NUMBER), you may assume that the record passed all edits and was applied to the LMMIS TPL Resource File.

Edits are applicable to required fields and may apply to Optional fields if you submit a value. If you receive an edit record, you may correct the issue and resubmit the record in a future submission.

Molina TPL File Layout to Plans

01	EB-OTHER-INS-DETAIL.	
05	OTHER-INS-RECIP-ID-CURR	PIC X(13).
05	OTHER-INS-RECIP-ID-ORIG	PIC X(13).
05	OTHER-INS-TYPE	PIC X(02).
88	PRIVATE-TPL	VALUE 'PR'.
88	MEDICARE-PART-A	VALUE 'MA'.
88	MEDICARE-PART-B	VALUE 'MB'.
88	LAHIPP	VALUE 'LH'.
05	OTHER-INS-COMPANY-NUMBER	PIC X(06).
05	OTHER-INS-SCOPE-OF-COVERAGE	PIC X(02).
05	OTHER-INS-MEDICARE-HIC-NO	PIC X(12).
05	OTHER-INS-BEGIN-DATE	PIC 9(08).
05	OTHER-INS-END-DATE	PIC 9(08).
05	OTHER-INS-GROUP-NO	PIC X(15).
05	OTHER-INS-POLICY-NO	PIC X(13).
05	OTHER-INS-POLICY-HOLDER-NAME	PIC X(20).
05	OTHER-INS-POLICY-HOLDER-SSN	PIC X(09).
05	OTHER-INS-AGENT-NAME	PIC X(25).
05	OTHER-INS-AGENT-PHONE	PIC X(10).
05	OTHER-INS-AGENT-STREET	PIC X(25).
05	OTHER-INS-AGENT-CITY	PIC X(20).
05	OTHER-INS-AGENT-STATE	PIC X(02).
05	OTHER-INS-AGENT-ZIP	PIC X(09).

Scopes of Coverage

Below is the list from the MDW DED:

Scope of Coverage	Description
00	Not Available
01	Major Medical
02	Medicare Supplement
03	Hospital, Physician, Dental and Drugs
04	Hospital, Physician, Dental
05	Hospital, Physician, Drugs
06	Hospital, Physician
07	Hospital, Dental and Drugs
08	Hospital, Dental
09	Hospital, Drugs
10	Hospital Only
11	Inpatient Hospital Only
12	Outpatient Hospital Only
13	Physician, Dental and Drugs
14	Physician and Dental
15	Physician and Drugs
16	Physician Only
17	Dental and Drugs Only
18	Dental Only
19	Drugs Only
20	Nursing Home Only
21	Cancer Only
22	CHAMPUS/CHAMPVA
23	Veterans Administration
24	Transportation
25	HMO
26	Carrier declared Bankruptcy
27	Major Medical without maternity benefits
28	HMO/Insurance Premium Paid by Medicaid GHIPP Program
29	Skilled Nursing Care
30	Medicare HMO (Part C)
31	Physician Only HMO
32	Pharmacy (PBM)
33	HMO No Maternity

Louisiana Medicaid Recipient Aid Category Codes

Aid Category	Short Description	Long Description
01	Aged	Persons who are age 65 or older.
02	Blind	Persons who meet the SSA definition of blindness.
03	Families and Children	Families with minor or unborn children.
04	Disabled	Persons who receive disability-based SSI or who meet SSA defined disability requirements.
05	Refugee Asst	Refugee medical assistance administered by DHH 11/24/2008 retroactive to 10/01/2008. Funded through Title !V of the Immigration and Nationality Act (not the Social Security Act - not Medicaid funds)
06	OCS Foster Care	Foster children and state adoption subsidy children who are directly served by and determined Medicaid eligible by OCS.
08	IV-E OCS/OYD	Children eligible under Title IV-E (OCS and OYD whose eligibility is determined by OCS using Title IV-E eligibility policy).
11	Hurricane Evacuees	Hurricane Katrina Evacuees
13	LIFC	Individuals who meet all eligibility requirements for LIFC under the AFDC State Plan in effect 7/16/1996.
14	Med Asst/Appeal	Individuals eligible for state-funded medical benefits as a result of loss of SSI benefits and Medicaid due to a cost-of-living increase in State or local retirement.
15	OCS/OYD Child	OCS and OYD children whose medical assistance benefits are state-funded. OCS has responsibility for determining eligibility for these cases. These children are not Title XIX Medicaid eligible.
16	Presumptive Eligible	Women medically verified to be pregnant and presumed eligible for Medicaid CHAMP Pregnant Woman benefits by a Qualified Provider.
17	QMB	Persons who meet the categorical requirement of enrollment in Medicare Part A including conditional enrollment.
20	TB	Individuals who have been diagnosed as or are suspected of being infected with Tuberculosis.
22	OCS/OYD (XIX)	Includes the following children in the custody of OCS: those whose income and resources are at or below the LIFC standard but are not IV-E eligible because deprivation is not met; those whose income and resources are at or below the standards for Regular MNP; those who meet the standards of CHAMP Child or CHAMP PW; and children aged 18-21 who enter the Young Adult Program.
30	1115 HIFA Waiver	LaChoice and LHP and GNOCHC
40	Family Planning	Family Planning Waiver

Louisiana Medicaid Recipient Type Case Codes

LAMMIS Type Case	Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions)	SSI Status (1=SSI, 0=Non-SSI)
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	0
002	Deemed Eligible	0
003	SSI Conversion	0
004	SSI SNF	1
005	SSI/LTC	1
006	12 Months Continuous Eligibility	0
007	LACHIP Phase 1	0
008	PAP - Prohibited AFDC Provisions	0
009	LIFC - Unemployed Parent / CHAMP	0
010	SSI in ICF (II)- Medical	1
011	SSI Villa SNF	1
012	Presumptive Eligibility, Pregnant Woman	0
013	CHAMP Pregnant Woman (to 133% of FPIG)	0
014	CHAMP Child	0
015	LACHIP Phase 2	0
016	Deceased Recipient - LTC	0
017	Deceased Recipient - LTC (Not Auto)	0
018	ADHC (Adult Day Health Services Waiver)	0
019	SSI/ADHC	1
020	Regular MNP (Medically Needy Program)	0
021	Spend-Down MNP	0
022	LTC Spend-Down MNP (Income > Facility Fee)	0

023	SSI Transfer of Resource(s)/LTC	1
024	Transfer of Resource(s)/LTC	0
025	LTC Spend-Down MNP	0
026	SSI/EDA Waiver	1
027	EDA Waiver	0
028	Tuberculosis (TB)	0
029	Foster Care IV-E - Suspended SSI	0
030	Regular Foster Care Child	0
031	IV-E Foster Care	0
032	YAP (Young Adult Program)	0
033	OYD - V Category Child	0
034	MNP - Regular Foster Care	0
035	YAP/OYD	0
036	YAP (Young Adult Program)	0
037	OYD (Office of Youth Development)	0
038	OCS Child Under Age 18 (State Funded)	0
039	State Retirees	0
040	SLMB (Specified Low-Income Medicare Beneficiary)	0
041	OAA, ANB or DA (GERI HP-ICF(I) SSI-No)	0
042	OAA, ANB or DA (GERI HP-ICF(I) SSI Pay)	1
043	New Opportunities Waiver - SSI	1
044	OAA, ANB or DA (GERI HP-ICF(2) SSI-Pay)	1
045	SSI PCA Waiver	1
046	PCA Waiver	0
047	Illegal/Ineligible Aliens Emergency Services	0
048	QI-1 (Qualified Individual - 1)	0
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	0
050	PICKLE	0

051	LTC MNP/Transfer of Resources	0
052	Breast and/or Cervical Cancer	0
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	0
054	Reinstated Section 4913 Children	0
055	LACHIP Phase 3	0
056	Disabled Widow/Widower (DW/W)	0
057	BPL (Walker vs. Bayer)	0
058	Section 4913 Children	0
059	Disabled Adult Child	0
060	Early Widow/Widowers	0
061	SGA Disabled W/W/DS	0
062	SSI/Public ICF/DD	1
063	LTC Co-Insurance	0
064	SSI/Private ICF/DD	1
065	Private ICF/DD	0
066	AFDC- Private ICF DD - 3 Month Limit	0
067	AFDC or IV-E(1) Private ICF DD	0
068	SSI-M (Determination of disability for Medicaid Eligibility)	1
069	Roll-Down	0
070	New Opportunities Waiver, non-SSI	0
071	Transitional Medicaid	0
072	LAMI Psuedo Income	0
073	Recipient (65 Plus) Eligible SSI/Ven Pay Hospital	1
074	Description not available	0
075	TEFRA	0
076	SSI Children's Waiver - Louisiana Children's Choice	1
077	Children's Waiver - Louisiana Children's Choice	0
078	SSI (Supplemental Security Income)	1
079	Denied SSI Prior Period	0

080	Terminated SSI Prior Period	1
081	Former SSI	1
082	SSI DD Waiver	1
083	Acute Care Hospitals (LOS > 30 days)	0
084	LaCHIP Pregnant Woman Expansion (185-200%)	0
085	Grant Review	0
086	Forced Benefits	0
087	CHAMP Parents	0
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	0
089	Recipient Eligible for Pay-Habitation and Other	0
090	LTC (Long Term Care)	0
091	A, B, D Recipient in Geriatric SNF; No SSI Pay	0
092	AFCD, GA, A, B, D in SNF; No AFDC Pay	0
093	DD Waiver	0
094	QDWI (Qualified Disabled/Working Individual)	0
095	QMB (Qualified Medicare Beneficiary)	0
097	Qualified Child Psychiatric	0
098	AFDC, GA, A, B, D ICF(2) No AFDC/Other Pay	0
099	Public ICF/DD	0
100	PACE SSI	1
101	PACE SSI-related	0
102	GNOCHC Adult Parent	0
103	GNOCHC Childless Adult	0
104	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	0
109	LaChoice, Childless Adults	0
110	LaChoice, Parents with Children	0
111	LHP, Childless Adults	0
112	LHP, Parents with Children	0

113	LHP, Children	0
115	Family Planning, Previous LAMOMS eligibility	0
116	Family Planning, New eligibility / Non LaMOM	0
117	Supports Waiver SSI	1
118	Supports Waiver	0
119	Residential Options Waiver - SSI	1
120	Residential Options Waiver - NON-SSI	0
121	SSI/LTC Excess Equity	1
122	LTC Excess Equity	0
123	LTC Spend Down MNP Excess Equity	0
124	LTC Spend Down MNP Excess Equity(Income over facility fee)	0
125	Disability Medicaid	0
127	LaChip Phase IV: Non-Citizen Pregnant Women Expansion	0
130	LTC Payment Denial/Late Admission Packet	0
131	SSI Payment Denial/Late Admission	1
132	Spendown Denial of Payment/Late Packet	0
133	Family Opportunity Program	0
134	LaCHIP Affordable Plan	0
136	Private ICF/DD Spendown Medically Needy Program	0
137	Public ICF/DD Spendown Medically Needy Program	0
138	Private ICF/DD Spendown MNP/Income Over Facility Fee	0
139	Public ICF/DD Spendown MNP/Income Over Facility Fee	0
140	SSI Private ICF/DD Transfer of Resources	1
141	Private ICF/DD Transfer of Resources	0
142	SSI Public ICF/DD Transfer of Resources	1
143	Public ICF/DD Transfer of Resources	0
144	Public ICF/DD MNP Transfer of Resources	0
145	Private ICF/DD MNP Transfer of Resources	0
146	Adult Residential Care/SSI	1

147	Adult Residential Care	0
148	Youth Aging Out of Foster Care (Chaffee Option)	0
149	New Opportunities Waiver Fund	0
150	SSI New Opportunities Waiver Fund	1
151	ELE - Food Stamps (Express Lane Eligibility-Food Stamps)	0
152	ELE School Lunch (Express Lane Eligibility -School Lunch)	0
153	SSI - Community Choices Waiver	1
154	Community Choices Waiver	0
155	HCBS MNP Spend down	0
178	Disabled Adults authorized for special hurricane Katrina assistance	0
200	CsoC-SED MEDICAID CHILD -MEDS TC and sgmt TC CSoC Waiver Children - 1915(c) waiver. Children under age 22, meeting a hospital and nursing facility LOC of CSoC will be eligibile up to 300% of FBR, using institutional eligibility criteria. LOC 60=hospital, 61=NF.	0
201	LBHP1915(i) NON MEDICAID ADULT 19 &OLDER CSoC Waiver Adults - 1915(i) only; non-Medicaid. Adults over the age of 18, not otherwise eligible for Medicaid, meeting the 1915(i) LON criteria up to 150% of FPL.	0
202	CSoC 1915(i)-LIKE MEDICAID CHILD sgmt 1915(i)-like Children (aka 1915(b)(3) children): temp type case on LTC segment if recipient is in LTC/NH/ICF. Otherwise Medicaid eligible children under age 22, meeting a LON of CSoC and eligible for additional services under 1915(b)(3) savings.	0
203	LBHP1915(i) MEDICAID ADULT 19 &OLDER sgmt CSoC Waiver Adults - 1915(i): temp type case on LTC segment if recipient is in LTC/NH/ICF. Adults over the age of 21, otherwise eligible for Medicaid, meeting the 1915(i) LON criteria.	0
204	LBHP1115-NON-MEDICAID ADULTS 19 & OLDER 1115 waiver for 1915(i) persons whose income is below 150% of FTPL and meeting the LON criteria. These individuals do not have to meet a category of assistance. The new aid cat/type case combination will be 40/204 and the segment temp type case will be	0

	204.	
205	LBHP Spend down (Adult)	

Appendix L

DHH Medicaid FI Transmission of Medicaid Enrollment/Eligibility Data to the Plan

- The FI utilizes a proprietary format to send all Louisiana Medicaid enrollment/eligibility data to the Plan.

- The FI sends an initial, comprehensive enrollment/eligibility file to the Plan at the initiation of production processes associated with the project.

- The FI sends work-day incremental enrollment/eligibility files to the Plan. The file is generated after the existing work-day MEDS-to-MMIS Recipient Update process.

- On a weekly basis the FI generates a comprehensive reconciliation file and sends it to the Plan. The Plan utilizes the “recon” file to ensure that their enrollment information is accurate. The Plan reports discrepancies to the DHH MEDS unit for disposition/resolution, which may require the Plan to correct their records.

Appendix M

File Transfer Schedule

Weekly (each Sunday):
Full Recipient information, including TPL data,
Full Provider information.

Weekly (each Tuesday):
Claims and Encounter History for the previous week's processing,
835 response file (from encounters submitted by MCNA in the previous week).

Weekly (each Thursday evening):
TPL response data (from TPL data submitted by MCNA).

Weekly (each Friday evening):
Provider registry response data (from provider registry data submitted by MCNA).

Daily (each work-day evening):
Incremental Recipient information, including TPL data,
Incremental Provider information.

Monthly (first work-day evening of the Month):
TPL Carrier Code information (third-party insurance company information).

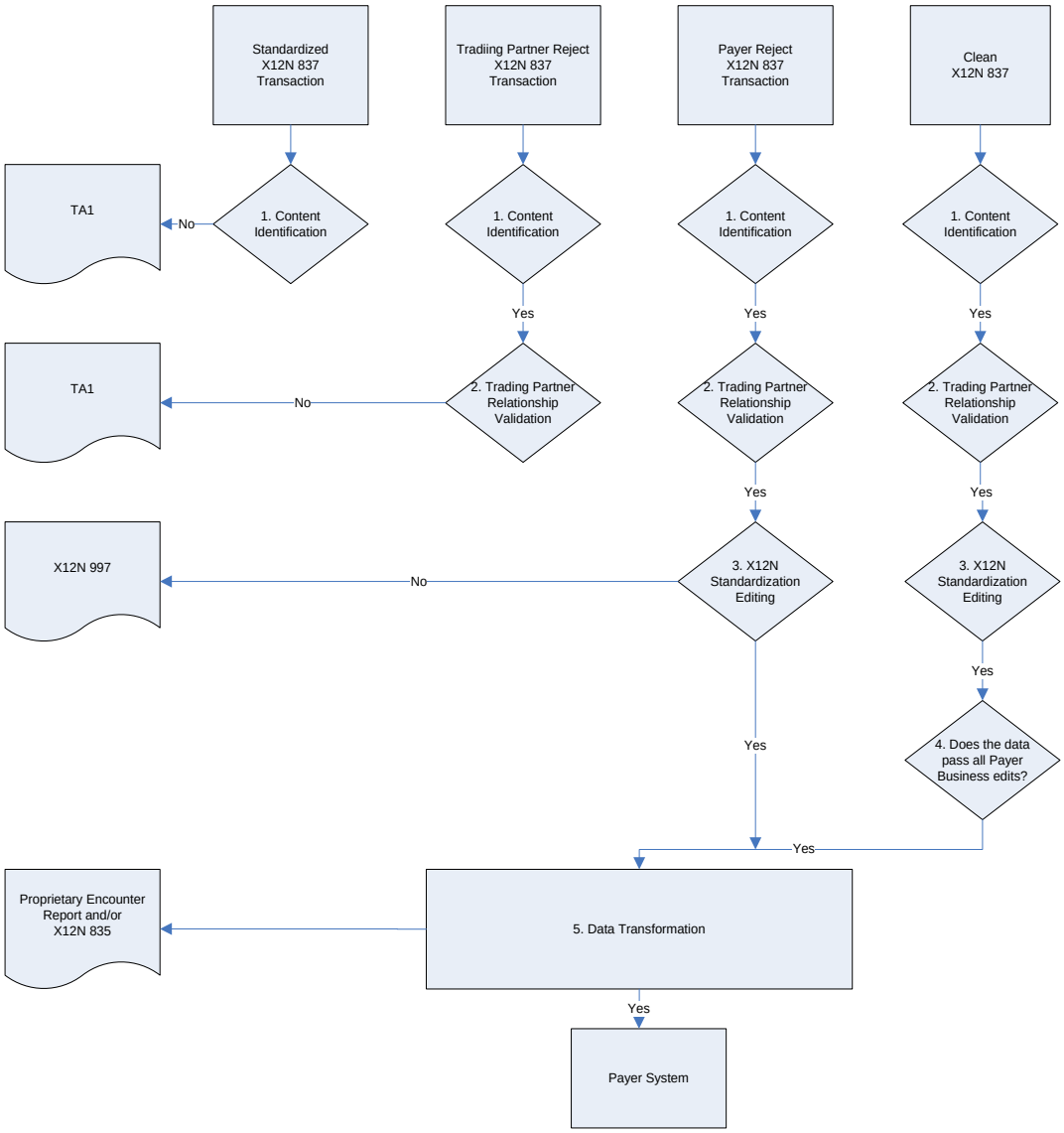
Monthly (as scheduled by DHH):
820 file showing detail of PMPM payments.

Appendix N

Process Flow Chart

The following process flow chart depicts an incoming ANSI ASC X12N 837 transaction validation for syntax of the FI Electronic Data Interchange (EDI).

Molina Electronic Data Interchange (EDI):
Incoming ANSI ASC X12N 837
Transaction Validation for Syntax



Appendix O

Encounter Data Certification Form

DHH – LA DEPARTMENT OF HEALTH AND HOSPITALS
ENCOUNTER DATA CERTIFICATION FORM

Please Type or Print Clearly

Dental Benefit Plan	**Name of Preparer/Title**
For The Period Ending **_____, 20____**	**Contact Phone Number/Email Address**

Plan DATA Certification Statement

On behalf of the above-named Plan, I attest, based on best knowledge, information and belief, that all data submitted to the DHH - LA Department of Health and Hospitals is accurate, complete, and true. This statement applies to all documents and files submitted to DHH.

I understand that any knowing and willful false statement or representation on this data submission form or attachment(s) may be subject to prosecution under applicable Federal and State laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the Plan contract.

File Type	ISA FILE #	Date File Sent (MMDDYR)	Total Number of Records	Sum Charged Amount	Sum of Paid Amount

Date Form Submitted:_____

Please circle as appropriate. Original Submission? Y N Void? Y N
Resubmission of Corrected or Voided Encounters ? Y N

Signature

This certification must be signed by the Chief Executive Officer or Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the Chief Executive Officer or Chief Financial Officer. Please check here if a delegated authority is certifying this submission _____

Date	MCO Chief Executive Officer/Delegate Name & Title	Signature
Date	MCO Financial Officer/Delegate Name & Title Officer/Delegate Name & Title	Signature